James M. Jesse, MD

TODAY'S DATE:_____

Patient Information

NAME:_____ AGE:_____ DATE OF BIRTH:_____

ADDRESS:_____ SEX:_____ MARITAL STATUS:_____

CITY:_____ STATE_____ ZIP_____ REFERRED BY WHOM _____

HOME PHONE:_____ DRIVERS LICENSE # State

SOCIAL SECURITY #:_____ PERMANENT ADDRESS: (if different) _____

EMPLOYER:_____ CITY/ST/ZIP:_____

ADDRESS:_____ HOME PHONE #:_____

CITY/ST/ZIP:_____ WORK PHONE #:_____

PHONE #:_____ Occupation _____

Responsible Party Information (If different from patient)

NAME:_____ RELATION TO PATIENT:_____

ADDRESS:_____ EMPLOYER:_____

CITY/ST/ZIP:_____ ADDRESS:_____

HOME PHONE:_____ CITY/ST/ZIP:_____

SOCIAL SECURITY #:_____ WORK PHONE:_____

CELL PHONE OTHER PHONE

Primary Insurance If you have an insurance card, please give it to the receptionist instead of filling out the section below

INSURANCE CO.:_____ POLICYHOLDER'S NAME:_____

ADDRESS:_____ POLICYHOLDER SSN:_____ D.O.B:_____

CITY/ST/ZIP:_____ POLICY #:_____

PHONE #_____ GROUP #:_____

Effective dates: _____ through _____ RELATION TO PATIENT:_____

PLAN NAME _____ COPAY $_____ POLICYHOLDER'S EMPLOYER:_____

Additional / Secondary Insurance

INSURANCE CO.:_____ POLICYHOLDER'S NAME:_____

ADDRESS:_____ POLICYHOLDER SSN:_____ D.O.B:_____

CITY/ST/ZIP:_____ POLICY #:_____

PHONE #_____ GROUP #:_____

Effective dates: _____ through _____ RELATION TO PATIENT:_____

PLAN NAME _____ COPAY $_____ POLICYHOLDER'S EMPLOYER:_____

Miscellaneous

In case of emergency, notify_____ Relation to patient_____

Home phone _____ Work phone _____

Pharmacy name _____ Pharmacy phone _____

Assignment & Release

I acknowledges that all of the above information is true and correct and that it has been furnished to this office with full knowledge that the patient is liable for all said services rendered and that he/she is contractually bound to pay for said services, including all costs of collection and a reasonable attorney's fee should collection become necessary. Patient hereby waives his/her confidentiality rights should collection action become necessary. I hereby authorize and request that payments under my insurance plans be made directly to Dr. Schlichting for any services furnished to me.

I hereby consent to the administration and performance of all diagnostic procedures and/or treatments which in the judgement of Dr. Schlichting may be considered necessary and advisable. I am entitled to a full explanation prior to any testing, procedure, or referral and that I have the option to decline such treatment or seek further information.

I also authorize the release of any information required to process insurance claims Including any information relating to alcohol, drug abuse, and/or AIDS. I authorize the release of my personal health information to: billing agencies, laboratories, diagnostic testing facilities, referring physicians, and others involved in the medical and/or financial aspects of my medical care. This authorization may be revoked in writing by me at ant time.

Signature:_____ Date:_____

(If patient is a minor - signature of parent/guardian)

MAGNIFIED FINE PRINT

I ain't lying	I acknowledges that all of the above information is true and correct
I am ultimately responsible for payment	and that it has been furnished to this office with full knowledge that the patient is liable for all said services rendered
I'll even let you add on the collection fee normally charged by collection agencies	and that he/she is contractually bound to pay for said services, including all costs of collection and a reasonable attorney's fee should collection become necessary.
I waive my protection under confidentiality if I don't pay.	Patient hereby waives his/her confidentiality rights should collection action become necessary.
I assign payments under my insurance to you directly.	I hereby authorize and request that payments under my insurance plans be made directly to Dr. Schlichting for any services furnished to me.
Go ahead and treat me.	I hereby consent to the administration and performance of all diagnostic procedures and/or treatments which in the judgement of Dr. Schlichting may be considered necessary and advisable. I am entitled to a full explanation prior to any testing, procedure, or referral and that I have the option to decline such treatment or seek further information.
Release my info...even the **special** cases of AIDS, drug/ETOH abuse	I also authorize the release of any information required to process insurance claims Including any information relating to alcohol, drug abuse, and/or AIDS.
HIPAA release of info	I authorize the release of my personal health information to: billing agencies, laboratories, diagnostic testing facilities, referring physicians, and others involved in the medical and/or financial aspects of my medical care.
I can change my mind anytime	This authorization may be revoked in writing at any time