

Houser-Norborg-MacGregor

PO Box 1598
 South Bend, IN 46634
 (574) 251-2103

PATIENT INFORMATION							
NAME (Last, First Middle)				MRN	SSN#	BIRTHDATE	SEX
LOCAL ADDRESS			CITY, STATE ZIP		SECONDARY/BILLING ADDRESS (if Applicable)		
HOME PHONE	DAY PHONE	EMAIL ADDRESS		REFERRING PHYSICIAN	CITY, STATE ZIP		
MARITAL STATUS	STUDENT STATUS <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	SMOKER (Y/N)?	VETERAN (Y/N)?	PRIMARY CARE PROVIDER	HOME PHONE		
PRIMARY EMPLOYER				SECONDARY EMPLOYER (if Applicable)			
ADDRESS				ADDRESS			
CITY, STATE ZIP				CITY, STATE ZIP			
WORK PHONE				WORK PHONE			

RESPONSIBLE PARTY INFORMATION (if Different than above)							
NAME (Last, First Middle)				SSN#	BIRTHDATE	SEX	
LOCAL ADDRESS			CITY, STATE ZIP		SECONDARY/BILLING ADDRESS (if Applicable)		
HOME PHONE	DAY PHONE	EMAIL ADDRESS		CITY, STATE ZIP			
MARITAL STATUS	STUDENT STATUS <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	SMOKER (Y/N)?	VETERAN (Y/N)?	PRIMARY CARE PROVIDER	HOME PHONE		
RELATIONSHIP TO PATIENT							

PRIMARY INSURANCE			
NAME OF INSURANCE COMPANY			POLICY#
NAME OF INSURED			GROUP#
ADDRESS OF INSURANCE COMPANY			COPAY AMT \$
CITY, STATE ZIP	PHONE	DEDUCTIBLE \$	
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (if Applicable)			
NAME OF INSURANCE COMPANY			POLICY#
NAME OF INSURED			GROUP#
ADDRESS OF INSURANCE COMPANY			COPAY AMT \$
CITY, STATE ZIP	PHONE	DEDUCTIBLE \$	
RELATIONSHIP TO PATIENT		EFFECTIVE DATE	EXPIRATION DATE

INSURANCE/SELF PAY AUTHORIZATION

I hereby authorize my physician to furnish information to insurance carriers or third party payors concerning my illness and treatments and I hereby assign to the physician(s) or Allied Physicians of Michiana all payment for medical services rendered to myself or my dependents. In the event I default on payment and this account is placed with an attorney or other agency for collection, I agree to pay reasonable attorney fees and/or collection agency fees, mediation fees and court costs incurred in the collection of my account balance as allowed by law.

SIGNATURE OF PATIENT/GUARDIAN

DATE