SIDDALL MEDICAL SERVICES, INC.

Patient Name: ______________________________
Last First Mi

Sponsor/Guardian: ______________________________
Last First Mi

Mailing Address: ______________________________

(If TriCare, we need your stop #) ______________________________
City State Zipcode

Cell #: ______________ Work #: ______________

Marital Status: S / M / D / W Gender: M / F SSN: ___-___-___ DOB: ___/___/___

Employer: ______________ Address: ______________

Status: Contractor ADAF AKANG Dependent DOD Other

Emergency Contact: ______________ Relationship: ______________ Phone: ______________

Regular Physician(s): ______________ Pharmacy: ______________

Insurance Information

Primary		Secondary	
Address:		Address:	
Phone #		Phone #	
Group #		Group #	
ID #		ID #	
Insured's Name		Insured's Name	
Relation to Patient		Relation to Patient	
DOB		DOB	

Initail

______________ I understand all payments for treatment received are my responsibility. I hereby acknowledge the release of any infromation to my insurance company that is required to process a claim on my behalf.

______________ I hereby authorize my insurance company to remit payment for any medical benefits due, directly to Siddall Medical Services. This authorization shall expire in one year or upon written notice.

______________ I also acknowledge that I have received or read a copy of Siddall Medical Services Notice of Privacy Practices, and I have been given an opportunity to ask any questions regarding these practices. I understand that I have a right to a copy of this notice upon my request.

Patient Signature: ______________________________ Date: ______________
(Signature of responsible party)
Relationship: ______________________________

You will need to provide a copy of your ID card and insurance cards at time of visit.