

HERBERT S GATES III, M.D.

Welcome to our practice.

PATIENT INFORMATION						
Patient Name	First	Middle	Last	Sex	Age	Date of Birth / /
What name do you prefer to be called?		Social Security Number			Marital Status	
Guarantor (if patient is a minor)		Social Security Number of Guarantor			Guarantor's Date of Birth	
Mailing Address		City	State	Zip Code		
Out of Town Mailing Address						
Home Phone Number ()			Out of Town Phone Number ()		Cell Phone Number ()	
Occupation:			Employer		Employer Phone Number ()	
Emergency Contact			Relationship		Phone Number ()	
I chose Dr. Gates because/Referred to Dr. Gates by (please check one box):			<input type="checkbox"/> Dr. _____		<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Hospital
<input type="checkbox"/> Family/Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Naples Daily News	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other _____		
Other family members seen here:						
Is this a liability case? <input type="checkbox"/> YES <input type="checkbox"/> NO				Name of Attorney		
If an accident, Where did it happen? <input type="checkbox"/> Home <input type="checkbox"/> Work Other _____			When?		What happened? Please give details of the accident or injury.	
INSURANCE INFORMATION						
Person responsible for payment			Primary Insurance Company (Please have your card ready to be copied)			
Policy Holder's Name			Insurance Company's Address			
Policy Holder's Employer			Policy Holder's Date of Birth	Policy #	Group #	

In order to establish optimal relations with our patients and avoid misunderstandings and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. You are responsible for bills and services rendered in this office and payment is required for all services at the time that they are rendered, unless prior arrangements have been made. As a courtesy, our office will file the appropriate insurance for you. However, you are required to pay any unmet deductible, non-covered services and co-payments. If we are forced to pursue collection against you for payment of our service, you will be liable for all costs and expenses incurred by such collection efforts including, without limitation, reasonable attorney's fees.

I give permission to release information relating to my medical treatment to my insurance company in order to process my claim for services and authorize payment of medical benefits to myself or party who accepts assignment. My signature below signifies my understanding of this policy, and acceptance of the terms stated herein.

Signature _____

Date _____