



DWITE D. DAHMS, M.D.

PIERRE DURAND, M.D.

GARY A. PATTEE, M.D.

MICHAEL T. VERCILLO, M.D.

PATIENT'S INSURANCE INFORMATION

Please present ALL insurance cards

PLEASE PRINT AND COMPLETE ALL SECTIONS!

Primary insurance company's name \_\_\_\_\_

Insurance address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Phone Number (    ) \_\_\_\_\_

Name of Insured \_\_\_\_\_ Sex: M    F    Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month    Day    Year

Relation to insured: Self    Spouse    Child    Other \_\_\_\_\_

Insurance ID# \_\_\_\_\_ Group Name \_\_\_\_\_ Group# \_\_\_\_\_

SECONDARY insurance company's name \_\_\_\_\_

Insurance address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Phone Number (    ) \_\_\_\_\_

Name of Insured \_\_\_\_\_ Sex: M    F    Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month    Day    Year

Relation to insured: Self    Spouse    Child    Other \_\_\_\_\_

Insurance ID# \_\_\_\_\_ Group Name \_\_\_\_\_ Group# \_\_\_\_\_

Check if appropriate: Retiree coverage \_\_\_\_\_ Medi-gap policy \_\_\_\_\_

PATIENT'S REFERRAL INFORMATION

Referred by \_\_\_\_\_ Your Primary Physician \_\_\_\_\_

EMERGENCY CONTACT

Name of person not living with you \_\_\_\_\_

Relationship \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (    ) \_\_\_\_\_ Work Phone(    ) \_\_\_\_\_ Cell Phone(    ) \_\_\_\_\_

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**RELEASE AND ASSIGNMENT OF BENEFITS & CONSENT FOR TREATMENT**

I hereby give authorization for payment of insurance benefits to be made directly to DAHMS, DURAND, PATTEE and VERCILLO M.D.'s for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

I also authorize the release of my medical records and any information regarding myself to any Physician, Dentist, or Insurance Company,

Date \_\_\_\_\_ Your Signature \_\_\_\_\_

I consent to and authorize the necessary evaluation and/or treatment in the course of my medical care. (Please refer to page 2, HIPAA info packet).

Date \_\_\_\_\_ Your Signature \_\_\_\_\_

Authorization to Treat a Minor: I hereby authorize DAHMS, DURAND, PATTEE and VERCILLO M.D.'s to perform physical examination, laboratory investigations, or other therapeutic treatment on my child.

Date \_\_\_\_\_ Your Signature \_\_\_\_\_

**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I, \_\_\_\_\_, have received the Notice of Privacy Practices from Dahms, Durand, Pattee and Vercillo M.D.

X \_\_\_\_\_ Date: \_\_\_\_\_

In lieu of patient signature, I, \_\_\_\_\_, a staff member of Dahms, Durand, Pattee and Vercillo M.D. state that \_\_\_\_\_ has been given our current Notice of Privacy Practices.

X \_\_\_\_\_ Date: \_\_\_\_\_

**SUMMARY OF OUR FINANCIAL POLICY**

I, \_\_\_\_\_, have received the Summary of Financial Policy from Dahms, Durand, Pattee and Vercillo M.D.

X \_\_\_\_\_ Date: \_\_\_\_\_