Date:	Patient Social Security #

Last Name First Name M.I.	Preferred Prefix	Sex	Marital Status	Race

Street Address	Birth Date	Age

City	State	Zip Code	Home Telephone	Cell Phone Number

Employer	Employer's Address	Work Telephone

Patient Email Address	Emergency Contact	Relationship	Telephone Number

Who is your preferred pharmacy?	Telephone Number	Other Important Contact Name	Relationship	Telephone Number

Responsible Party

(Complete this section only if you are listed as a dependent on someone else's insurance)

Responsible Party's Social Security #

Responsible Party's Name Last Name First Name M.I.	Preferred Prefix	Sex	Marital Status

Street Address	Birth Date	Relationship to Patient

City	State	Zip Code	Home Telephone	Cell Phone Number

Employer	Employer's Address	Work Telephone

How did you find out about us?

_____

Insurance Company	Insured	Policy #	Group #	Deductible	Co-Pay

Street Address for claims:	City	State	Zip Code	Telephone Number

Please specify your insurance company's preferred lab. (N/A for Medicare)	My insurance company requires referrals/precerts for: (N/A for Medicare)

If you are a member of a managed care plan, please read and sign below:

I have checked with my insurance company and verified that the provider I'm seeing is a participating provider on my insurance plan. If a referral from another provider is required before seeing the providers of James S. Linder, M.D., I agree that it is my responsibility to obtain such a referral. It is also my responsibility to advise the office in advance if precertifications are needed. If my insurance company requires the use of a specific lab, I have listed it above. If any charges remain unpaid because I have not provided the proper information itemized above or because services are not covered by my plan, I agree to be personally liable for those charges.

*X*_____

Patient/Responsible Party

Secondary Insurance

Insurance Company	Insured	Policy #	Group #	Deductible	Co-Pay

Street Address for claims:	City	State	Zip Code	Telephone Number

Medical Records Confidentiality

(Please read and sign below)

My signature below indicates that I have been given a copy of James S. Linder, M.D.'s Notice of Privacy Practices For Protected Health Information. Unless I specifically indicate disagreement below, I agree that my protected health information may be used according to the policies itemized in the confidentiality policy. Without in any way limiting the Practices, I agree that James S. Linder, M.D., may release my records to other health care providers involved with my care, prescriptions may be faxed to pharmacies, and records may be released to any company who is expected to pay for services rendered to me, and messages may be left at my home or my personal cell phone concerning appointments and test results provided the individual answering the phone identifies himself as an adult member of my family such as a spouse or parent. Messages may also be left on my home or personal cell phone answering machine.

*X*_____

Patient/Responsible Party

My records may not be used according to James S. Linder, M.D.'s policies in the following ways: _____

Is there any additional information we need to properly file your insurance?