## PATIENT INFORMATION

Patient's last name_____ First name_____ M.I._____

Birthdate_____ Address_____ City_____

State_____ Zip_____ Primary Care MD_____

Home phone_____ Work Phone_____ Cell_____

Email_____SS#_____Occupation_____

Employer's name_____

Employer's address_____

Marital status S M D W Separated Last visit with Dr. Modly _____

Name of spouse or Parent/Guardian_____

Name and phone # of emergency contact_____

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## INSURANCE INFORMATION

Please present ALL insurance cards to the receptionist

PRIMARY_____ Policy #_____ Group #_____

Policyholder/relationship_____ DOB_____

Policyholder's employer_____

Policyholder's employer's address_____

SECONDARY_____ Policy #_____ Group #_____

Policyholder/relationship_____ DOB_____

**Assignment of Benefits**

I hereby assign all medical and /or surgical benefits, to include major medical benefits to which I am entitled to Charlotte E. Modly, MD for services rendered by Charlotte E. Modly, MD This assignment will remain in affect until revoked by me in writing. A photocopy of this assignment is to e considered valid as the original. I hereby assume financial responsibility for all charges whether or not paid by insurance. I hereby authorize said assignee to release all necessary information to secure payment. I understand that Charlotte E. Modly, MD reserves the right to pursue delinquent account via third party collection agencies or attorneys and that I am responsible for any collection fees incurred by Charlotte E. Modly, MD.

Signature_____ Date_____