Patient name_____DOB:_____

SSN#_____ Marital status _____Sex_____

Street_____

City _____ State _____Zip _____

Phone (Home or Cell)_____Phone (W)_____

Referring Doctor_____

Emergency Contact:_____Relationship_____Phone_____

Pharmacy_____

Are you? Employed____ Unemployed____ Retired____ Student____

Employers' name _____Phone _____

MEDICATIONS:
Please give the list of your medications to my assistant to make a copy OR write it down:

_____
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ALLERGIES:_____

Private insurance authorization for assignment of benefits and information release:
I, the undersigned, authorize payment of medical benefits to David Bjelica, MD A Medical Corporation for any services furnished to me. I understand I may be financially responsible for any amount not covered by my insurance. If requested, I also authorize you to release to my insurance company information concerning health care, treatment or supplies provided to me. I also understand that the doctor's office reserves the right to charge a monthly late fee of $39.00 for outstanding balances not paid within 60-day grace period.

Signature: _____Date: _____

Thank you!