Michelle M. Louis D.O.

Patient Information Form (please print)

Patient Name_____**Date**_____
Street Adresss_____**Home Phone**_____
City_____**State**_____**Zip**_____**Work Phone**_____
Have You Ever seen Dr. Louis Before?_____**Referred by**_____
Social Security #_____**Marital Status**_____**Date of Birth**_____
Patient Employer Name_____**Occupation**_____
Address_____**Phone Number**_____

Spouse or Parent/Guardian Information

Name_____**Social Security#**_____
Address_____
Employer Name_____**Phone Number**_____
Address_____

PRIMARY INSURANCE:

Who Owns Primary Insurance policy? Patient_____ **Spouse**_____ **Parent**_____
Name of Policy_____
Claims Mailing Address_____
Group Name or Number_____**Patient I.D. #**_____
Owner of Insurance Policy_____**Date of Birth**_____

Secondary Insurance:

Who Owns Secondary Insurance policy? Patient_____ **Spouse**_____ **Parent**_____
Name of Policy_____
Claims mailing Address_____
Group Name or Number_____**Patient I.D. #**_____
Owner of Insurance Policy_____**Date of Birth**_____

Please Note that you are responsible to make Dr. Michelle Louis your Primary Care Physician if your Insurance Policy requires this for coverage.

Assignment of Insurance Benefits

Please Read & Sign The Following:

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.

I directly assign all medical benefits to Michelle Louis, D.O, and understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Dr. Louis to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this original shall be as valid as the original.

SIGN HERE_____**DATE**_____

Authorization To Release Test Results

I give my consent to the office of Dr. Louis to release any test results ordered by this office to the following person if I am unavailable.

NAME_____Relationship_____

PHONE_____Address_____

Signature_____Date_____