WHITE HALL FAMILY MEDICINE * Information Change Form

PATIENT NAME _____ DATE OF BIRTH _____

SEX M F SOCIAL SECURITY NUMBER _____ RACE _____

MAILING ADDRESS _____ MARITAL STATUS S M W D

TELEPHONE HOME _____ WORK _____ CELL _____

EMPLOYER _____ CONTACT & TELEPHONE NUMBER FOR EMPLOYER'S BENEFIT INFORM _____

EMAIL ADDRESS _____ PHARMACY _____

SPOUSE'S NAME _____ SPOUSE'S EMPLOYER & TELEPHONE NUMBER _____

PARENT/GUARDIAN (IF UNDER 18) _____ PARENT/GUARDIAN EMPOYER _____

EMERGENCY CONTACT (OUTSIDE THE HOME) NAME AND TELEPHONE NUMBERS

1 _____ CELL # _____ OTHER # _____

2 _____ CELL # _____ OTHER # _____

PRIMARY INSURANCE	SECONDARY INSURANCE
COMPANY	COMPANY
ADDRESS	ADDRESS
ID NUMBER	ID NUMBER
GROUP NUMBER	GROUP NUMBER
INSURED NAME (AS IT APPEARS ON CARD)	INSURED NAME (AS IT APPEARS ON CARD)
SOCIAL SECURITY NUMBER	SOCIAL SECURITY NUMBER
INSURED'S DATE OF BIRTH	INSURED'S DATE OF BIRTH

PAYMENT REQUIRED AT THE TIME OF SERVICE-UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE

ALL INSURANCE CARDS ARE REQUIRED AT TIME OF CHECK IN

ASSIGNMENT OF INSURANCE BENEFITS

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 insurance companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, coinsurance, or any other balance not paid for by your insurance.

I HEREBY AUTHORIZE DIRECT PAYMENT OF MEDICAL / SURGICAL BENEFITS TO MARK RAMIRO, MD / DOUG COLEMAN, MD, FOR SERVICES RENDERED BY HIM IN PERSON OR UNDER HIS SUPERVISION. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE NOT COVERED BY MY INSURANCE.

AUTHORIZATION TO RELEASE INFORMATION

I HEREBY AUTHORIZE MARK RAMIRO, MD, / DOUG COLEMAN, MD, TO RELEASE ANY MEDICAL OR INCIDENTAL INFORMATON THAT MAY BE NECESSARY FOR EITHER MEDICAL CARE OR IN PROCESSING APPLICATION FOR FINANCIAL BENEFIT.

MEDICARE / MEDICAID

I CERTIFY THAT THE INFORMATION GIVEN BY ME IN APPLYING FOR PAYMENT IS CORRECT. I AUTHORIZE RELEASE OF ALL RECORDS ON REQUEST. I REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF

A PHOTOCOPY OF THESE ASSIGNMENTS SHALL BE VALID AS THE ORIGINAL

PATIENT NAME (PLEASE PRINT)	DATE
PARENT/GUARDIAN (PLEASE PRINT)	DATE

SIGNATURE PATIENT, PARENT OR GUARDIAN

White Hall Family Medicine

Doug Coleman, MD
Mark Ramiro, MD

1400 Claud Road
White Hall, Arkansas 71602

Office 870-247-9499
Fax 870-247-5312