

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Medicare Eligible:** \_\_\_ yes\_\_\_no

E-mail address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Best phone number to contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May we leave a message?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Emergency Contact (name and number):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any individuals that we may discuss your medical information:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender: \_\_\_\_Male \_\_\_Female Marital Status:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authorized Credit Card #\_\_\_\_\_\_\_\_\_\_\_\_\_ Exp Date:\_\_\_\_\_\_ CSC: \_\_\_\_

 Zip Code for Card: \_\_\_\_\_\_\_\_\_

2020

Please note: Full payment is required at the time of service. WE DO NOT PARTICIPATE WITH ANY INSURANCE PLANS. Patients are responsible

for filing their own insurance claims. A receipt for services will include the insurance codes necessary for he filing process. Gandolph Health Care is not responsible for any insurance denial or partial reimbursement. Please check with your insurance regarding coverage for any tests or labs that your doctor might order.

Medicare patients are hereby informed that we have OPTED OUT of the

Medicare program. Medicare patients are required to inform Gandolph

Health Cares should they become eligible for the Medicare program.

If you are Medicare eligible, please complete the **opt out form**.

I have read the previous statements and understand that full payment is expected at the time of service.

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

While we do not participate in insurance plans, some of the tests our doctors order might be covered by your plan. Please provide your insurance information **FOR REFERENCE ONLY**.

insurance provider:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

member number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

group number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ insurance phone:\_\_\_\_\_\_\_\_\_\_\_\_\_