

PATIENT INFORMATION- DAVID L. DURST, M.D.

PATIENT'S NAME		MARITAL STATUS S M W DIV SEP	DATE OF BIRTH	AGE	SEX
STREET ADDRESS		CITY AND STATE	ZIP CODE	HOME PHONE	
CELL PHONE		E-MAIL ADDRESS			
PATIENT'S EMPLOYER	OCCUPATION	HOW LONG EMPLOYED	BUSINESS PHONE		
EMPLOYER'S STREET ADDRESS		CITY AND STATE	ZIP CODE		
SOCIAL SECURITY NUMBER		DRIVER'S LICENSE NUMBER			
SPOUSE'S NAME		SPOUSE'S EMPLOYER	WORK NUMBER		
SPOUSE'S SOC. SEC. NUMBER		EMPLOYER'S ADDRESS			
EMERGENCY CONTACT(OTHER THAN SPOUSE)		DAYTIME PHONE NUMBER			
REASON FOR VISIT		REFERRING DOCTOR / OTHER REFERRAL			
HAVE YOU SEEN ANOTHER PHYSICIAN ABOUT CURRENT PROBLEM/CONCERN? IF YES, WHO?					
MAY WE LEAVE A MESSAGE FOR YOU REGARDING (PLEASE CIRCLE)					
	HOME PHONE	BUSINESS PHONE	CELL PHONE		
APPTS:	YES NO	YES NO	YES NO		
LAB REPORTS:	YES NO	YES NO	YES NO		
SURGERY FOLLOW UP:	YES NO	YES NO	YES NO		
IF THE PATIENT IS A MINOR OR STUDENT					
MOTHER'S NAME	STREET ADDRESS, CITY, STATE AND ZIP CODE			HOME PHONE	
MOTHER'S EMPLOYER	OCCUPATION	HOW LONG EMPLOYED?	BUSINESS PHONE		
FATHER'S NAME	STREET ADDRESS, CITY, STATE AND ZIP CODE			HOME PHONE	
FATHER'S EMPLOYER	OCCUPATION	HOW LONG EMPLOYED?	BUSINESS PHONE		
INSURANCE INFORMATION			INSURANCE INFORMATION		
INS. COMPANY NAME AND ADDRESS			INS. COMPANY NAME AND ADDRESS		
POLICY NUMBER OR CONTRACT NO.			POLICY NUMBER OR CONTRACT NO.		
EFFECTIVE DATE			EFFECTIVE DATE		
NAME OF POLICYHOLDER			NAME OF POLICYHOLDER		
GROUP NUMBER			GROUP NUMBER		
<p>IN ORDER TO CONTROL OUR COST OF BILLING, WE REQUEST THAT OFFICE VISITS BE PAID AS SERVICES ARE RENDERED. I AUTHORIZE PAYMENT OF ALL MEDICAL AND SURGICAL BENEFITS DIRECTLY TO DAVID L. DURST, M.D. I REALIZE THAT ALL CHARGES INCURRED BY ME OR MY DEPENDENTS ARE MY FINANCIAL RESPONSIBILITY AND ALL COURT FEES, ATTORNEY FEES OR OTHER FEES NECESSARY TO COLLECT THIS AMOUNT ARE PAYABLE TO ME.</p>					
DATE		PATIENT/RESPONSIBLE PARTY			