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 REFFERAL

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

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 DAVID L. DURST, M.D.

DATE ____________ **PATIENT/RESPONSIBLE PARTY** ____________