Casey G. Boyer M.D., P.A.
Board Certified Internal Medicine

Patient Name: _____
(Last) (First) (Middle)

Sex: M__ F__ Check One: Married:___ Single:___ Widowed:____ Divorced :____

Race: _____ Ethnicity: _____ Primary Language: _____ Advanced Directives: Yes ___ No ___

Date Of Birth: _____ Email :_____

Patients Local Address: _____

Permanent Address: (If Different) _____

Home Phone # : (____) _____ Cell # : (____) _____

Employed By:_____ Occupation: _____ Work #: (___) _____

Emergency Contact: _____ Relationship:_____ Phone : (___) _____

Allergies To Medications: _____

Primary Pharmacy: _____ _____Phone: _____

Previous Primary Care Physician: _____Phone: _____

Referred By: _____Reason For Visit:_____

Check One: Illness / Injury Related To : Work __ Auto __ Other __ Date Of Incident: _____

Primary Insurance: _____ HMO ___PPO ___ POS ___

Policy/ID # _____Group # _____

Policy Holder: _____ ___Relationship: _____ Policy Holder's Date Of Birth: _____

Secondary Insurance Company Name: _____

Policy/ ID #_____ Group # _____

Policy Holder :_____Relationship :_____Date Of Birth : _____

_____ _____
Print Patient's Name Patient's Signature

Date: _____ _____

Witness Signature

ASSIGNMENT OF BENEFITS

INSURANCE CARRIERS CERTIFICATION FOR PAYMENT

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO PHYSICIAN OF BENEFITS DUE ME FOR HIS SERVICES. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR CHARGES NOT COVERED BY THIS AUTHORIZATION.

DATE: _____ SIGNATURE: _____

I AUTHORIZE THE **RELEASE OF ANY MEDICAL INFORMATION** NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR THE PARTY WHO ACCEPTS ASSIGNMENT.

DATE: _____ SIGNATURE: _____

LIFETIME AUTHORIZATION MEDICARE CERTIFICATION FOR PAYMENT

I CERTIFY THAT THE INFORMATION GIVEN BY ME IN APPLYING FOR PAYMENT UNDER THE TITLEXVII OF THE SOCIAL SECURITY ACT IS CORRECT. I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION OR ITS INTERMEDIARIES OR CARRIERS ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE CLAIM. I REQUEST THAT THE PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF. I ASSIGN THE BENEFITS PAYABLE FOR PHYSICIAN SSERVICES TO THE PHYSICIAN OR ORGANIZATION FURNISHING THE SERVICES OR AUTHOIZE SUCH PHYSICIAN OR ORGANIZATION TO SUBMIT A CLAIM TO EDICARE FOR PAYMENT TO ME.

I REQUEST THAT THIS AUTHORZATION ALSO APPLY TO ALL OTHER INSURANCE.

DATE: _____ SIGNATURE: _____

TITLE OR RELATIONSHIP _____

IF SIGNED BY OTHER THEN BENEFICIARY, STATE THE REASON THE PATIENT IS UNABLE TO SIGN.

_____

LIFETIME SIGNATURE MEDIGAP POLICY HOLDERS

I REQUEST THAT PAYMENT OF AUTHORIZED MEDIGAP BENEFITS BE MADE ON MY BEHALF TO CASEY G. BOYER M.D., PA. FOR ANY SERVICES FURNISHED ME BY DR. BOYER. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO (NAME OF MEDIGAP INSURER) ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BEEFITS PAYABLE FOR RELATED SERVICES.

DATE_____ SIGNATURE _____