

DATE: _____

THE OFFICE OF DR. STEPHAN J. LaPOINTE

NAME:
FIRST _____ MI _____ LAST _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

SS# _____ DATE OF BIRTH ____/____/____ AGE: _____ SEX: M ___ F ___

MARITAL STATUS: SINGLE ___ MARRIED ___ DIVORCED ___ OTHER ___

HOME PHONE () _____ WORK PHONE () _____ EXT _____

EMPLOYER _____ ADDRESS _____

SPOUSE'S NAME: _____ SS# _____ DOB ____/____/____

SPOUSE'S EMPLOYER _____ WORK NUMBER _____

RESPONSIBLE PARTY (IF OTHER THAN PATIENT)

NAME: _____ RELATIONSHIP _____

DOB: ____/____/____ SS# _____

ADDRESS: _____ CITY _____ STATE _____

HOME PHONE: () _____ EMPLOYER: _____

WORK PHONE# _____ EXT _____

EMERGENCY CONTACT NOT LIVING WITH YOU: _____

RELATIONSHIP: _____ HOME PHONE: _____

WORK PHONE: _____ EXT _____

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1.

INSURANCE INFORMATION

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PRIMARY: _____ POLICY # _____ GROUP # _____

POLICY HOLDER'S NAME: _____ DOB: ____/____/____

SECONDARY: _____ POLICY # _____ GROUP # _____

POLICY HOLDER'S NAME: _____ DOB: ____/____/____

I hereby give Dr. LaPointe and/or his associates permission to examine and treat my foot or leg problems. If insurance is filed, I authorize payment to be made to me, or the doctor. I further authorize the release of any medical information necessary to process claims. I accept full responsibility for any charges on this account. I understand that should I neglect to pay my bill and allow my account to be turned over to a collection agency, a collection fee of up to 40% of the balance due will be added back to my account. I understand it is my responsibility to understand my insurance benefits and that this office is happy to provide care within my insurance companies guidelines as long as I make them aware of these guidelines. If I do not properly inform the office of special requirements, and services/supplies are ordered that are not covered, I will be billed for the charge. With cooperation between this office and myself, I should be able to receive all of the benefits offered, while being able to concentrate on caring for my medical needs. I have read and understand the office policy stated above and agree to accept responsibility as described.

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