

Slater Medical Arts, Inc

OCCUPATIONAL
HEALTH CONSULTANT

CHRIS B. SLATER, D.O.

PATIENT INFORMATION

DATE _____ SSN _____ DATE OF BIRTH _____
NAME _____ HOME PHONE _____
ADDRESS _____ CELL PHONE _____
CITY _____ STATE _____ ZIP CODE _____
MALE ___ FEMALE ___ MINOR ___ SINGLE ___ MARRIED ___ DIVORCED ___ WIDOWED ___ STUDENT ___
EMPLOYER _____ WORK PHONE _____
BUSINESS ADDRESS _____ OCCUPATION _____
EMERGENCY CONTACT _____ PHONE NUMBER _____

INSURANCE INFORMATION

PERSON RESPONSIBLE FOR ACCOUNT _____
RELATIONSHIP TO PATIENT _____ D.O.B. _____ S.S.N. _____
ADDRESS _____ HOME PHONE _____
CITY _____ STATE _____ ZIP _____
EMPLOYED BY: _____ BUSINESS PHONE _____
INSURANCE COMPANY _____
ID NUMBER _____ GROUP NUMBER _____

ASSIGNMENT AND RELEASE

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO **SLATER MEDICAL ARTS CLINIC** FOR ALL INSURANCE BENEFITS OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES WHETHER PAID BY INSURANCE OR NOT, AND FOR ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.
I AUTHORIZE THE ABOVE DOCTOR AND/OR PROVIDER OR SUPPLIER OF SERVICES IN THIS OFFICE TO RELEASE ANY INFORMATION REQUIRED TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

DATE