RICHARD L. ALEXANDER II, M.D.

Date: ___________________

Legal Patient Name ____
Last First M.I.

Nickname____

Home Address ____

City _______________________________________State ____________Zip Code _______

Home Phone _______________________________Cell Phone ______________________________

Birthdate __________________________________SS# ___________________________________

Patient Employed By _________________________________Occupation_____________________

Employer Address ____

City _____________________ State _______Zip Code________ Phone ______________________

Spouse/Parent Name ____
Last First M.I.

Spouse Birthdate ___________________________ SS# __________________________________

Spouse Employed By _______________________________Occupation______________________

Address ____

City _____________________ State _______Zip Code ________Phone______________________

Emergency Contact Person Other Than Spouse:
Name ____ Relationship _________________

Address_______________________________City_______________State_______ZipCode______

Phone____

Referred By ____

Who is financially responsible for your bill: Patient ( ) Other ( ) ___________________________

OUR POLICY IS PAYMENT IN FULL AT TIME OF SERVICE. IF YOU HAVE INSURANCE PLEASE PAY ANY COPAYMENT OR DEDUCTIBLE THAT YOU OWE. WE WILL SUBMIT INSURANCE CLAIMS FOR YOU. PLEASE PROVIDE US WITH YOUR CURRENT INSURANCE ID CARD.

Primary Insurance____

Secondary Insurance ____

ASSIGNMENT & RELEASE: I hereby assign my insurance benefits to be paid directly to the undersigned physician. I am financially responsible for non-covered services. I also authorize the physician to release to my insurance carriers any information required to process my claims.

SIGNED: ____Date __________________
Patient or Parent, if minor