William M. Schnitz, M.D.

Patient Information
(Please Print)

NAME: (Last) ____________________ (First)______________(Middle)______________

ADDRESS: (PLEASE NO P.O. BOXES OR ROUTE NUMBERS)

____ APT. #______________

CITY: _______________________ STATE: _________ ZIP CODE: _______________

Home Phone: ______________________ Work Phone: _________________________

Cell: ______________________________ Other: ____________________________

(Optional) Email Address: _________________________________

May we email your appointment reminders/medical information to you? ____Yes ____No

MAILING ADDRESS: (IF DIFFERENT THAN STREET ADDRESS)

____ APT. #_______________

CITY: _____________________ STATE: _________ ZIP CODE: _________________

SOCIAL SECURITY NUMBER: _______-______-_________ SEX: __Male __Female

DATE OF BIRTH: (Month) ______________ (Day)________ (Year)__________

MARITAL STATUS: Single Married Divorced Legally Separated Widowed

EMPLOYMENT STATUS: Student Employed Unemployed Retired Disabled

EMPLOYER: _________________________ POSITION: _________________________

PHONE: _____________________________ SUPERVISOR: _____________________

RESPONSIBLE PARTY INFORMATION: (PARENTAL INFO. IF PATIENT IS UNDER 18)

NAME: ____

STREET ADDRESS: _______________________________________ APT. #_________

CITY: _________________________ STATE: _________ ZIP CODE: _____________

HOME PHONE: ________________ CELL: _______________ WORK: ____________

EMERGENCY CONTACT: ____________________________ PHONE: _____________

PHARMACY NAME: ________________________ PHONE: ______________________

PHARMACY ADDRESS: ____

SIGNED: ______________________________________ DATE: ____________________

William M. Schnitz, M.D.

Patient Insurance Information

Please give your insurance card(s) to the receptionist

How did you hear about Dr. Schnitz?
Doctor ___________________ Patient Insurance Phone Book Other ______________

INSURANCE INFORMATION: *ALL INFORMATION MUST BE COMPLETED*

PRIMARY **INSURANCE COMPANY:** ____
POLICY NUMBER: _______________________ **GROUP NUMBER:** _________________
POLICY HOLDER NAME: _______________________ **DATE OF BIRTH:** ____________
SOCIAL SECURITY NUMBER: ______-_____-_______
RELATIONSHIP TO PATIENT: SELF SPOUSE PARENT LEGAL GUARDIAN

SECONDARY **INSURANCE COMPANY:** ____
POLICY NUMBER: _______________________ **GROUP NUMBER:** __________________
POLICY HOLDER NAME: _______________________ **DATE OF BIRTH:** _____________
SOCIAL SECURITY NUMBER: ______-_____-_______
RELATIONSHIP TO PATIENT: SELF SPOUSE PARENT LEGAL GUARDIAN

All professional services rendered are charged to the patient. Necessary forms will be complete to expedite insurance claims. The patient in responsible for all co-payments, deductibles, patien portions, and fees not otherwise covered by insurance. It is customary to pay for services when rendered unless arrangements are made in advance, regardless of insurance coverage. Please READ and SIGN the following authorization and assignment.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize William M. Schnitz, M.D. to furnish information to my insurance carrier(s) concerning my illness and treatments. I hereby assign to the doctor all payments for medical services rendered to my dependents or myself. I understand that I am responsible for any amou not covered by insurance. I also agree that a photocopy of this authorization shall be considere as valid as the original.

SIGNED: ____ DATE: _______________________

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