

BONE & JOINT INSTITUTE, P.C.
GERALD J. JERRY, M.D.
RAFIA KHALIL, M.D.
JEFFREY DENT, PA-C
2611 ELECTRIC AVENUE
SUITE E
PORT HURON, MICHIGAN 48060
TELEPHONE (810) 967-9671
FAX (810) 967-6070

PATIENT INFORMATION SHEET

Date: _____ Home Phone: () _____

Patient Name: _____
(Last) (First) (Mid. Initial)

Social Security No: _____ Birthdate: _____

Address: _____
(Street Address) (City, State, Zip)

Marital Status: S M W D (Circle) Sex: M ___ F ___

Patient's Employer: _____

Address: _____
(Street Address) (City, State, Zip)

Work Phone No. : () _____ How Long There? _____

Occupation: _____

Spouses' SS #: _____

Address: _____

Work Phone No. : () _____

Who is responsible for this account? _____

Relationship to patient: _____

Type of Insurance: _____ Insured's Name: _____

Contract #: _____ Group #: _____

Workers' Comp? Yes ___ No ___ If yes, date of injury: _____

Auto Accident? Yes ___ No ___ If yes, date of accident: _____

*** Emergency Contact: (other than home) Name: _____

Phone #: () _____ Relationship: _____

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ASSIGNMENT & RELEASE: (For all insurances other than Medicare)

I, the undersigned have insurance coverage with the mentioned company on the registration form. I assign to Gerald J. Jerry, Jr., M.D., all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature of Insured/Patient: _____

Date: _____

MEDICARE AUTHORIZATION:

I request that payment of authorized Medicare benefits be made to either me, or on my behalf to Gerald J. Jerry, Jr., M.D. for any services furnished me to release to the HCFA, and/or it's agents any information needed to determine these benefits, or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other healths insurance is indicated in item 9 of HCFA-1500 form or elsewhere on other approved claim forms or assigned cases, the physician or supplier agrees to accept the charge determined by the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance and non-covered services. Co-insurance and deductible are based upon the charge determination of the Medicar carrier.

Signature of Insured/Patient: _____

Date: _____