TWIN LAKES MEDICAL ASSOCIATES, PC PATIENT INFORMATION FORM

Twin Lakes Medical Associates, pc Ted Miklas MD-1891712873

NAME			DOB//
LAST	FIRST	MIDDLE	
		× .	
CELL PHONE	HOME PHONE	WORK	
ADDDECO		OCCUPATION AND A STATE OF THE S	
ADDRESS	2	SOCIAL SECURITY #	
		MALE FEMALE	
		MARITAL STATUS M D W	
EMERGENCY CONTACT		PHONE	
EMERGENOT CONTACT		PHONE	
	INSTIDANCE CADE	RIER INFORMATION	
GUARANTOR	SAME AS PATIENT	OTHER (if other please complete below)	
ADDRESS	•	EMPLOYER	
(*acumant adiau The adultanadiau uta baira a sia	71 h		
(*payment policy: The adult/guardian who brings a minor	will be responsible for all copays and	deductibles. We do not forward bills to other	parties regardless of court rulings.)
POLICY HOLDER			
FOLIGITIOLDER			
PRIMARY INSURANCE CARRIER	ID#	GROUP	
THINDIT INSCIPCIOL CATHER	10#	GROUP	
OFFICE VISIT CO	PAY	DEDUCTIBLE	
		Just of Habita	
SECONDARY INSURANCE CARRIER	ID#	GROUP	
DO YOU GIVE OUR OFFICE PERMISSION TO DISCUS	S YOUR MEDICAL INFORMATION	WITH FAMILY MEMBERS? YES	NO
IF YES, PLEASE INDICATE WHOM WE MAY DISCUSS	YOUR INFORMATION WITH		
NAME:	RELATIONSHIP	PHONE	
PLEASE SIGN BELOW SO WE MAY HAVE YOUR INSU	RANCE AUTHORIZATION ON FILE		
I, THE PATIENT LISTED ABOVE, AUTHORIZE AND AG	REE TO THE TERMS IN THE AUTH	ORIZATION AND AGREEMENT FOR MEDIC	AL TREATMENT POLICY,
PROVIDED BY TWIN LAKES MEDICAL ASSOCIATES. I	ACKNOWLEDGE ALL PATIENT R	ESPONSIBILITIES AND HAVE REVIEWED TI	HSES TERMS. ONLY SERVICES
THAT ARE CONSIDERED MEDICALLY NECESSARY W	ILL BE BILLED TO MY CURRENT H	HEALTH INSURANCE. IT IS MY RESPONSIB	LITY TO KEEP THIS OFFICE
INFORMED OF ANY CHANGES TO MY HEALTH INSUF	RANCE COVERAGE, AND TO OBTA	IN A REFERRAL FOR ALL MEDICAL SERVIC	CES, THROUGH MY PRIMARY
CARE, IF APPLICABLE. I AUTHORIZE ANY HOLDER O	F MEDICAL OR OTHER INFORMAT	ION ABOUT ME TO RELEASE A COPY OF T	'HIS AUTHORIZATION TO BE
USED IN PLACE OF THE ORIGINAL, AND REQEST PA	YMENT OF MEDICAL INSURANCE	BENEFITS TO MYSELF OR THE PARTY WH	O ACCEPTS THE ASSIGNMENT.
TODAYS DATE	_		
SIGNATURE	,		
PLEASE PROVIDE YOUR INSURANCE CA	ARDS AND DRIVERS LICEN	ISE TO THE RECEPTIONIST WIT	H THIS FORM
PATIENT			
SIGNATURE			
OIGHY TO LL			