George A. Patterson III M.D. (08/10)

Name ________________________________ Male ( ) Female( ) Married( ) Single( )

Address ________________________________ Apt ______ City____________________ ZIP_______

Home Phone _________________ Work Phone _________________ Date of birth ___________

Social Security # ________________________ Employer//School ______________________

Occupation___________________________ Part-time( ) Student Full( ) Part ( )

Referred by ____________________________ Medical Doctor ______________________

Email___________________________________ Cell Phone _________________________

Patients relationship to insured: Self( ) Spouse( ) Child ( ) Other ( )

Primary insurance ____

Address: ____

Name of Subscriber ______________________ Date of birth _____________________

Group # _______________________ Policy # ________________ Employer ______________

Secondary Insurance ____

Address: ____

Name of Subscriber ____________________ Date of birth _________________________

Group #__________________ Policy # __________________ Employer ________________

I hereby authorize George A. Patterson III MD to apply for benefits on my behalf for covered services. I certify that the information I have reported is correct and further authorize the release of any necessary information including medical information to this or any related claim. All accounts are due in full 30 days after the insurance has paid. There will be a $40.00 charge for any checks returned by our bank. If your account is unpaid after 90 days it will be sent to our attorney for collection. You will then be responsible for collection costs including attorney fees, court costs and expenses related to reporting the account to the credit bureaus.

____________________________________ ________________________

Signature of subscriber or beneficiary date