Welcome to the office of Dr. Ron W. Pelton

What is the reason for your visit today?_____

PATIENT INFORMATION

Date of Visit_____

Social Security #_____

Patient Name _____

_____

Address_____

City_____

State_____ Zip_____

Sex ____ M ____F Age_____ Birthdate_____

Marital Status_____

Occupation_____

Patient
Employer_____

Employer Address_____

Employer Phone Number_____

Spouse's Name_____

Birthdate_____ SS#_____

Spouses Employer_____

Whom may we thank for referring you?

_____

PHONE NUMBERS

Home _____ ____ Cell_____

Best time and place to reach you_____

Email_____

In case of Emergency, contact

Name_____

Relationship_____

Home Phone_____

Other Phone_____

INSURANCE INFORMATION

Who is Responsible for this account?

_____

Subscriber's Name_____

Relationship to Patient_____

Birthdate_____ ___ SS#_____

Insurance Co._____

Insurance ID#_____ Group #_____

Is the patient covered by additional insurance? ____Yes ____No

Subscriber's Name_____

Birthdate_____ ___ SS#_____

Relationship to Patient_____

Insurance Co._____

Insurance ID#_____ Group #_____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I have insurance coverage with

_____

and assign directly to Dr. Ron W. Pelton, M.D., PhD all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Dr. Ron W. Pelton, M.D., PhD may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

MEDICARE/MEDIGAP AUTHORIZATION

I request payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made to either me or on my behalf to Dr. Ron W. Pelton, M.D., PhD for any services furnished to me by that provider. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

Signature_____

Beneficiary or Guardian_____

Relationship to Beneficiary_____ Date_____

FAMILY HISTORY

Are there any diseases or conditions that run in your family? Please List_____

	Age	Medical Conditions	If deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Brothers	_____	_____	_____
Sisters	_____	_____	_____
Children	_____	_____	_____

YOUR PHYSICIANS

Primary Care_____

Eye Doctor_____

Other_____

_____

_____

MEDICATIONS NONE

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

DO YOU USE HOW MUCH

Caffeine ____Yes ____No _____

Tobacco ____Yes ____No _____

Alcohol ____Yes ____No _____

Other ____Yes ____No _____

PREVIOUS SURGERIES DATE

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

MEDICAL CONDITIONS NONE

_____

_____

_____

_____

_____

_____

Pharmacy Name_____

Phone Number_____

List medication allergies NONE

_____

_____

_____

_____

To the best of my knowledge, the above information is correct. I understand that it is my responsibility to inform my doctor if I, or my minor child ever have a change in health.

Signature_____ Date_____

Print Name_____ Relationship to Patient_____

Reviewed by_____ Date_____