

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?  
 \_\_\_\_\_

**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 \_\_\_\_\_

**PHONE NUMBERS**

Home \_\_\_\_\_ Cell \_\_\_\_\_  
 Best time and place to reach you \_\_\_\_\_  
 Email \_\_\_\_\_  
**In case of Emergency, contact**  
 Name \_\_\_\_\_  
 Relationship \_\_\_\_\_  
 Home Phone \_\_\_\_\_  
 Other Phone \_\_\_\_\_

**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	_____	_____	_____

