

F. MARK OWSLEY, M.D.

PATIENT INFORMATION SHEET

PATIENT NAME: _____
Last first (Legal) middle

MAILING ADDRESS: _____

PHYSICAL ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

HOME PHONE: _____ **CELL PHONE:** _____

EMPLOYER: _____ **S.S. NUMBER:** _____

WORK PHONE: _____ **BIRTHDATE:** _____ **Age:** _____

SEX: MALE _____ **FEMALE** _____ **MARITAL STATUS: M** _____ **S** _____

SPOUSES NAME:

ALTERNATE PHONE #: _____ **NAME:**

HOW DID YOU HEAR ABOUT US: _____

INSURANCE INFORMATION

PRIMARY INSURANCE CO: _____ **GROUP#** _____ **ID#** _____

SUBSCRIBER NAME: _____
Last First Middle

RELATIONSHIP TO PATIENT: _____ **SUBSCRIBERS DOB** _____

SUBSCRIBERS EMPLOYMENT: _____

By signing below I acknowledge that I have received a copy of Dr. Owsley's health insurance portability & accountability act (HIPPA) brochure.

I understand that I am fully responsible for all charges, whether or not covered by said insurance. I hereby authorize F. Mark Owsley, M.D., or Patrick J. Mullen, M.D., to release all information necessary to secure payment that my insurance company may request concerning my illness or injury. I hereby assign to F. Mark Owsley, M. D. or Patrick J. Mullen, M.D., and all payment to which I am entitled for medical and/or surgical expenses relative to the service reported for my illness or injury. I understand that I am financially responsible to said doctor for charges not covered by this assignment of benefits. A photocopy of this assignment is as valid as the original.

TO MY KNOWLEDGE ALL THE ABOVE INFORMATION IS TRUE AND CORRECT.

DATE : _____ SIGNATURE: _____
(IF MINOR LEGAL GUARDIAN)

PRINT LEGAL GUARDIAN NAME: _____