Linda L. Burk, M.D.

PATIENT INFORMATION:

Ms. Mr.
Miss. Dr.
Mrs. Rev.

_____ _____ _____
First Name **MI** **Last Name**

_____
Home Address

_____ _____ _____
Zip Code **City** **State**

_____
Social Security

_____ _____ _____ _____
DOB **Age** **Marital Status** **Sex**

_____
Referring Physician

_____
Referring Physician Phone Number

Home #: (_____) _____-_____
Work #: (_____) _____-_____
Emergency: # (_____) _____-_____ (Name: _____)
Other #: (_____) _____-_____
Mobile #: (_____) _____-_____
Fax #: (_____) _____-_____
Email Address: _____

EMPLOYER INFORMATION:

_____ _____
Name of Company **Occupation**

_____
Address

_____ _____ _____
Zip Code **City** **State**

Employer
Contact Person: _____

Phone # :(_____) _____-_____

Fax #: (_____) _____-_____

Other #: (_____) _____-_____

SPOUSE, PARENT OR RESPONSIBLE PARTY INFORMATION:

_____ _____ _____ **Relationship to patient _____**
First Name **MI** **Last Name**

_____
Social Security Number

_____ _____ _____ _____
DOB **Age** **Marital Status** **Sex**

_____ _____
Employer **Occupation**

Home #: _____
Work #: _____
Emergency #: _____
Pager #: _____

INSURANCE INFORMATION: (Please include Medicare/ Medicaid)

Primary Insurance Comp _____
Insurance ID # _____
Insurance Group # _____
Relation to Insurance Holder _____
Name of Insured _____
Insured DOB _____

Secondary Insurance Comp_____
Insurance ID# _____
Insurance Group # _____
Relationship to Insurance Holder _____
Name of Insured _____
Insured DOB _____

HMO, POS, EPO Participants: I understand that without an authorization or referral from my insurance carrier I will be responsible for all charges incurred.

I authorize release of any Medical Information necessary to process this claim or to another medical specialty for care and treatment and AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE UNDERSIGNED PHYSICIAN FOR SERVICE.

Patient's Signature or Authorized Signature _____ Date: _____

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