

University Medical Professionals

PATIENT INFORMATION

Name: Error Test	Date of Birth:
Address One:	Social Security #:
Address Two:	Sex: M
City:	PCP/Ref Dr.:
State: Zip:	Employer:
Home Phone#:	Emergency Contact:
Work Phone#:	Emergency Phone#:
Cell Phone#:	Emergency Relationship:

How did you hear about our office? _____

GUARANTOR INFORMATION

Name:	Date of Birth:
Address One:	Social Security#:
Address Two:	
City:	Employer:
State: Zip:	Employer Address:
Home Phone#:	Employer City:
Work Phone#:	Employer State: Zip:
Cell Phone#:	

INSURANCE INFORMATION

Primary Insurance:	Secondary Insurance:
Certificate#:	Certificate#:
Group Number:	Group Number:
Group Name:	Group Name:
Copay:	Copay:
Subscriber Name:	Subscriber Name:

Authorization To Pay Benefits To Physician: I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to myself or to my Provider, University Medical Professionals when they accepts assignment.

Authorization To Release Medical Information. I hereby authorize my Provider, University Medical Professionals to release any information necessary for my course of treatment.

Signed (patient or parent if minor)

Date