Jeffrey M. Blake, M.D.

Marilyn E. Frazier. RN, NP
2/13

PATIENT INFORMATION & CONSENT

(All Spaces Must Be Completed)

PATIENT NAME _____ BIRTH DATE _____
(Last) (First) (MI)

STREET ADDRESS _____ CITY _____ STATE_____ ZIP_____

HOME PHONE _____ WORK PHONE_____ CELL PHONE_____

YOUR EMPLOYER_____ SOCIAL SECURITY # _____

EMPLOYER'S ADDRESS _____
Street Address City State Zip

MARITAL STATUS: (S) (M) (W) (D) NAME OF SPOUSE _____BIRTH DATE _____

PREFERRED PHARMACY (Name/Address)_____

E-Mail:_____ Preferred language: (English) (Spanish) Other:_____

*RACE: (Amer.Indian) (Asian) (Black or African Amer) (White/Caucasian) (Refuse to Report/Unknown) (Native Hawaii./Pacific Islander)
*ETHNICITY: (Hispanic or Latino) (Non-Hispanic or Latino) (Refuse to Report) **Required by federal government.*

PRIMARY INSURANCE CO. _____ ID # _____ GROUP#_____

INSURED'S NAME_____ RELATIONSHIP _____ BIRTH DATE _____

EMPLOYED? Y N IF YES: EMPLOYER _____

SECONDARY INSURANCE CO. _____ ID #_____ GROUP#_____

INSURED'S NAME_____RELATIONSHIP _____ BIRTH DATE _____

EMPLOYED? Y N IF YES: EMPLOYER_____

If patient is a minor, or party responsible is someone other than the patient:

RESPONSIBLE PARTY _____ ADDRESS_____

RELATIONSHIP_____ EMPLOYER _____ SOCIAL SECURITY # _____

BIRTH DATE_____ Sex: M___ F_____ PHONE #_____

FAMILY PHYSICIAN_____Address_____ Phone_____

EMERGENCY CONTACT NAME_____phone:_____Relationship_____

CONSENT FOR MEDICAL INFORMATION & TREATMENT OF MINOR:

I, the undersigned parent or legal guardian of above patient, give permission for the office of Jeffrey M. Blake, M.D., Inc. to assess and treat said patient.

Printed name:_____ Signature: _____

Relationship to Patient:_____ Witness Signature:_____Date:_____Time: _____

Please **initial** each space

____I authorize payment of medical benefits to Jeffrey M. Blake, M.D., Inc.

____I authorize release of information to my insurance carrier(s) for processing and to any collection agency/ attorney hired by provider.

____I authorize Jeffrey M. Blake, M.D., Inc. to share my medical records/medications/care with other providers as needed.

____I understand that I shall be responsible for all fees incurred for service provided to me and my dependents, regardless of insurance coverage. I further acknowledge I will be responsible for reasonable collection fees, attorney's fees and court costs incurred in any attempt by provider to collect amounts I may owe. I will be responsible for missed visit (>24 hour notice cancellation) fees of $25 or $50 for diet consults/urodynamics' (>48 hours' notice cancellation) appointments.

____I understand that in the event my account becomes overdue, and monthly payments are not made, I will be charged $10 each month for a billing fee, unless other arrangements have been made.

____I understand that co-pays are required at the time of visit; if not paid, charges may be added to cover billing for the unpaid co-pay.

____ I authorize the office of Jeffrey M. Blake, M.D., Inc. to speak and/or leave phone messages and/or fax messages regarding my medical care/appointment reminders/account at my home or cell number and with the following (names/relationships):_____

_____ This will remain valid until revoked in writing by me.

SIGNATURE of patient: _____DATE:_____

SIGNATURE of responsible party (if other than patient):_____DATE:_____