
# Jeffrey S. Leider, M.D., P.C.

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**EMAIL:**

**ACCT#:**_____

**PATIENT INFORMATION** (FILL OUT COMPLETELY)

PATIENT'S NAME:_____SS#_____DOB:__/__/__

STREET ADDRESS:_____ CITY&STATE:_____ZIP:_____

PHONE (HOME):_____(WORK/CELL):_____

Marital Status: M ☐ S ☐ W ☐ D ☐ SEX: M ☐ F ☐

**BEST DAYTIME PHONE NUMBER FOR DOCTOR TO CONTACT YOU:**_____

ANY KNOWN DRUG ALLERGIES:_____

CONTACT PERSON IN CASE OF EMERGENCY: (NAME)_____(PHONE)_____

**INSURANCE INFORMATION (PLEASE READ): YOU ARE DIRECTLY RESPONSIBLE FOR PAYMENT OF YOUR ACCOUNT SHOULD A PROBLEM ARISE WITH YOUR INSURANCE. YOUR INSURANCE IS A CONTRACT BETWEEEN YOU, YOUR EMPLOYEE, AND THE INSURANCE COMPANY. WE ARE NOT A PARTY TO THAT CONTRACT.**

POLICY HOLDER'S NAME FOR INSURANCE:_____SS#_____

ADDRESS (IF DIFFERENT THAN ABOVE):_____

CITY&STATE:_____ _____ZIP: _____

PHONE (HOME):_____(WORK/CELL):_____DOB:__/__/__

PATIENT OR GUARDIAN'S EMPLOYER:_____OCCUPATION:_____

RELATIONSHIP TO PATIENT:_____

**PRIMARY INSURANCE INFORMATION:**

INSURANCE COMPANY:_____

POLICY #:_____

GROUP #:_____

SUBSCRIBER:_____

DATE OF BIRTH:__/__/__

INSURANCE PHONE #:_____

**SECONDARY INSURANCE INFORMATION:**

INSURANCE COMPANY:_____

POLICY #:_____

GROUP #:_____

SUBSCRIBER:_____

DATE OF BIRTH:__/__/__

INSURANCE PHONE #:_____

**PHYSICIAN'S INFORMATION:** WOULD YOU LIKE TO HAVE A LETTER REGARDING TODAY'S VISIT SENT TO YOUR DOCTOR?

☐ YES ☐ NO

**PRIMARY PHYSICIAN:**_____PH:_____FX:_____

ADDRESS:_____CITY&STATE:_____ZIP:_____

**REFERRING PHYSICIAN:**_____PH:_____FX:_____

ADDRESS:_____CITY&STATE:_____ZIP:_____

**THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS. IT IS ALSO CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE WITH OUR OFFICE BOOKKEEPER.**

**INSURANCE AUTHORIZATION AND ASSIGNMENT:**

NAME OF POLICY HOLDER:_____

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE/OTHER INSURANCE COMPANY BENEFITS BE MADE WHETHER TO ME OR ON MY BEHALF TO DR. LEIDER FOR ANY SERVICES FURNISHED ME BY THAT PARTY WHO ACCEPTS ASSIGNMENT/PHYSICIAN REGULATIONS PERTAINING TO MEDICARE ASSIGNMENT OF BENEFITS APPLY. I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION AND HEALTH CARE FINANCING/ADMINISTRATION OR ITS INTERMEDIARIES OR CARRIER OR ANY OTHER INSURANCE COMPNANY ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE/OTHER INSURANCE COMPANY CLAIM.

I UNDERSTAND MY SIGNATURE REQUESTS THAT PAYMENT BE MADE AND AUTHORIZES RELEASE OF MEDICAL INFORMATION NECESSARY TO PAY THE CLAIM TO THE INSURER OR AGENCY SHOWN. IN MEDICARE AND INSURANCE WE PARTICIPATE IN, PHYSICIAN OR SUPPLIER AGREES TO ACCEPT THE CHARGE DETERMINATION OF THE MEDICARE/OTHER COMPANY AS THE FULL CHARGE. AND THE DEDUCTIBLE IS BASED UPON THE CHARGE DETERMINATION OF THE MEDICARE/OTHER INSURANCE COMPANY.

**SIGNATURE**_____**DATE**_____