John B. Roach, Jr., D.O.

PATIENT INFORMATION TODAY'S DATE_____

NAME_____

ADDRESS_____

CTY_____STATE_____ZIP_____

SS#_____DATE OF BIRTH_____

MARITAL STATUS_____HOME PHONE_____ CELL PHONE _____

RACE_____ ETHNICITY_____ PREFERRED LANGUAGE_____

EMPLOYER_____ WORK PHONE_____
Employer Address/State/ZIP_____

REFERRED BY_____

REASON FOR VISIT_____

EMAIL ADDRESS_____

Emergency contact & Phone number_____

Do you have a healthcare proxy/power of attorney? (if yes please provide name) _____
**if yes, please also provide a copy of your POA for your chart
Do you have a living will? _____ Do not resuscitate? _____

PHARMACY _____ PHONE NUMBER_____

PLEASE PRESENT INSURANCE CARD AND DRIVERS LICENSE TO RECEPTIONIST

TO THE EXTENT NECESSARY TO DETERMINE LIABILITY FOR PAYMENT AND TO OBTAIN REIMBURSEMENT, I AUTHORIZE DISCLOSURE OF PORTIONS OF THE PATIENTS RECORD. I HEREBY ASSIGN ALL MEDICAL BENEFITS TO JOHN B. ROACH JR. D.O.. I ALSO AUTHORIZE THE RELEASE OF INFORMATION IN MY RECORDS TO THE INSURANCE COMPANY OR OTHER PARTIES TO JUSTIFY CLAIMS FILED. THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. A PHOTOCOPY OF THIS ASSIGNMENT IS TO BE CONSIDERED AS VALID AS AN ORIGINAL. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY SAID INSURANCE. I HEREBY AUTHORIZE SAID ASSIGNEE TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT.

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PATIENT/RESPONSIBLE PARTY SIGNATURE DATE SIGNED