CLIFFORD E. MYERS, M.D.
5401 N. Knoxville, Suite 106
Peoria, IL 61614
Phone: 693-2710

Your appointment is scheduled for:

_____

WELCOME TO OUR OFFICE

(PLEASE PRINT)

PATIENT'S NAME _____ SEX: MALE _____ FEMALE _____

PATIENT'S DATE OF BIRTH _____ AGE _____

PATIENT'S ADDRESS - STREET _____ PHONE _____

PATIENT'S CITY AND STATE _____ ZIP CODE _____ CELL _____

PATIENT'S EMPLOYER _____ ADDRESS _____ PHONE _____

EMPLOYER'S CITY _____ STATE _____ ZIP CODE _____

PATIENT'S SPOUSE _____

SPOUSE'S EMPLOYER _____ ADDRESS _____

SPOUSE'S EMPLOYER'S CITY _____ STATE _____ PHONE _____

FATHER'S NAME (if child) _____

FATHER'S ADDRESS (if different) _____

FATHER'S CITY _____ STATE _____ PHONE _____

FATHER'S EMPLOYER _____ ADDRESS _____

MOTHER'S NAME (if child) _____

MOTHER'S ADDRESS (if different) _____

MOTHER'S CITY _____ STATE _____ PHONE _____

MOTHER'S EMPLOYER _____ ADDRESS _____

PATIENT REFERRED BY: _____

INSURANCE CARRIER — PLEASE SHOW INSURANCE CARDS AT DESK

MEDICARE NUMBER _____

SUPPLEMENTAL INSURANCE _____ POLICY NUMBER _____

INSURANCE CO. ADDRESS _____

ILLINOIS PUBLIC AID CARD YES _____ NO _____

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. IF REQUESTED, NECESSARY FORMS WILL BE COMPLETED TO EXPEDITE INSURANCE CARRIER PAYMENTS. THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I HEREBY AUTHORIZE CLIFFORD E. MYERS, M.D. TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO THE PHYSICIAN(S) ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

DATE _____ SIGNATURE _____