CLIFFORD E. MYERS, M.D. 5401 N. Knoxville, Suite 106

Peoria, IL 61614 Phone: 693-2710

WELCOME TO OUR OFFICE

(PLEASE PRINT)

	rour appo	munent is
scheduled for:	scheduled	for:

PATIENT'S NAME		SEX: MALI	E FEMA	LE
		PATIENT'S DATE OF BI	RTH	_AGE
PATIENT'S ADDRESS - STREET		PHONE	·	
PATIENT'S CITY AND STATE	and the growth and the property and property and the property of the property of the second section is a	ZIP CODE	CELL	
PATIENT'S EMPLOYER	ADDRESS		PHONE	
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SPOUSE'S EMPLOYER'S CITY	\$ ⁻	TATEPHON	NE	
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MOTHER'S NAME (if child)	ang makangang se at a aya min specific in min mengapagan se at a mengahan pelapan pelapan se			t time talah da sajarah sajarah da kamanan sajarah kadan sajarah sajarah sajarah sajarah sajarah sajarah sajar
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PATIENT REFERRED BY:		olimbi melajikan kililara permakan melani melanakan sakan menangan gerbagan menangan kerangan dari melangan da		
NSURANCE CARRIER — PLEASE SHOW INSURANCE CA	ARDS AT DESK			
MEDICARE NUMBER				
SUPPLEMENTAL INSURANCE		POLICY NUMBER		
NSURANCE CO. ADDRESS				
LLINOIS PUBLIC AID CARD YES		*		

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