Date_____

PATIENT_____

MALE_____ FEMALE_____ AGE _____ DOB_____

SINGLE____ MARRIED _____ WIDOWED_____ DIVORCED_____

ADDRESS_____

CITY/ZIP_____HOME PHONE_____

CELL PHONE_____

RESPONSIBLE PARTY (IF MINOR)_____

EMPLOYER_____

EMPLOYER ADDRESS_____

EMPLOYER PHONE_____

IN CASE OF EMERGENCY, NOTIFY_____

PHONE_____CELL PHONE_____

DRUG STORE NAME_____PHONE_____

SS#_____INSURANCE _____

POLICY #_____ SUBSCRIBER_____

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorized the release of my information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I_____

(SIGNATURE OF INSURED)

Hereby authorize my insurance company to pay and hereby assign directly to Kenmore Family Medicine, LLP all benefits, if any, otherwise payable to me for medical services as described on the attached forms. I understand I am individually responsible for all charges incurred. I further acknowledge that my insurance benefits, when received by and paid to Kenmore Family Medicine, LLP will be credited to my account in accordance with the above agreement.