connecticutsurgicalarts,llc

Richard J. Martin, M.D., D.M.D.

159 SACHEM STREET • NORWICH, CT 06360
PHONE: 860.885.0444 fax: 860.885.0816

PATIENT INSURANCE INFORMATION

WELCOME TO OUR OFFICE. SO THAT WE MAY ASSIST YOU IN FILING YOUR HEALTH INSURANCE FORMS, PLEASE PROVIDE US WITH THE INFORMATION REQUESTED BELOW. ALL INFORMATION IS KEPT CONFIDENTIAL.

PATIENT'S NAME_____DATE_____

AGE_____ BIRTH DATE_____ SEX: M F SOC. SECURITY #_____

ADDRESS_____

CITY_____ STATE_____ ZIP_____

HOME PHONE_____ CELL PHONE_____

PLACE OF EMPLOYMENT_____ WORK PHONE_____

IN CASE OF EMERGENCY_____ _____ _____
(NAME) (RELATIONSHIP) (PHONE)

MEDICAL INSURANCE INFORMATION.

Insurance Co. Name & Address	
Employer Group ID#	
Subscriber Name and Relationship Self Spouse Birthdate_____ Dependent	

DENTAL INSURANCE INFORMATION.

Insurance Co. Name & Address	
Employer Group ID#	
Subscriber Name and Relationship Self Spouse Birthdate_____ Dependent	

ADDITIONAL MEDICAL INS. (SECONDARY)

Insurance Co. Name & Address	
Employer Group ID#	
Subscriber Name and Relationship Self Spouse Birthdate_____ Dependent	

ADDITIONAL DENTAL INS. (SECONDARY)

Insurance Co. Name & Address	
Employer Group ID#	
Subscriber Name and Relationship Self Spouse Birthdate_____ Dependent	

ASSIGNMENT AND RELEASE

I HEREBY ASSIGN ALL MEDICAL AND/OR SURGICAL BENEFITS TO: RICHARD J. MARTIN, M.D., D.M.D. OF CONNECITCUT SURGICAL ARTS, LLC. 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 DISCLOSE ALL PROTECTED HEALTH INFORMATION NECESSARY TO SECURE PAYMENT, RENDER TREATMENT, AND PERFORM HEALTH CARE OPERATIONS.
SIGNATURE OF Patient/Guardian _____ DATE_____