DR GHISLAINE ROBERT

Date: ____/____/_____

Patient Name:_____
First Middle Initial Last

Address:_____

_____
City State Zip

Phone Numbers: _____
Home Cell Work

Employer: _____ Email: _____

Date of Birth:_____Social Security Number:_____

Gender: M F Marital Status: Student Single Married Divorced Widowed
(Circle One)

Person responsible for bill/Account Guarantor:

_____

Spouse Name:_____Date of Birth:_____

Emergency Contact:_____Phone: _____

May we leave a detailed message on your answering machine if we are unable to reach you? yes_____ no_____

What is your pharmacy of choice: _____

CONSENT FOR TREATMENT, ASSIGNMENT OF BENEFITS & RELEASE OF INFORMATION

I hereby authorize you to evaluate and treat me (or my dependent). I have reviewed the information given and confirm it to be true. I understand that I am financially responsible for any bills incurred on this account, regardless of insurance coverage or third party liability. I further understand that in the event this account should go to collections I am responsible for all collection and legal fees and expenses. I hereby authorize assignment of insurance benefits to be paid directly to Dr Ghislaine Robert MD.

I authorize release of information to my insurance company(s). I authorize the use of this signature on all insurance submissions. A photocopy of this document is considered as valid as the original.

Date_____ Guarantor's Signature_____