MEDICAL CLINIC OF BELLAIRE, P.A.
DR. ESTHER GUY

Patient Information

Name: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

Home Phone: _____ Cell Phone: _____ SS#: _____

Marital Status*: (circle one)* Single Married Widowed Divorced Separated Sex *(circle one) M* F

Emergency Contact: _____ Relationship to Patient: _____

Phone: _____ How did you hear about us? _____

Patient /Spouse Employer Information

Patient Employer: _____ Spouse's Employer: _____

Phone: _____ Phone: _____

Patient Occupation: _____ Spouse's Occupation: _____

Insured Person/Policyholder (if not patient)

Name: _____ Phone: _____

Address: _____ City/State/Zip: _____

Relationship to Patient: _____ Date of Birth: _____

AUTHORIZATION FOR TREAMENT:

I authorize Dr. Esther Guy to perform medical procedures as she deems necessary for the treatment of my condition.

AUTHORIZATION FOR ASSIGNMENT:

I hereby authorize payment directly to Medical Clinic of Bellaire, PA. Any changes to this authorization must be received in writing.

I agree to release any/all my medical information, including test results and financial information to process this and any future claims to my insurer/payor of health benefits.

Patient/Responsible Party: X_____ Date: _____