Marc Mandel, M.D., F.A.C.S.

Patient Information Sheet

Please Print Clearly

Last Name:_____ **First Name:**_____

Birth Date:_____ **Age:**_____ **M/F:**_____

Social Security No._____ **If minor, Parent's SS#**_____

Address:_____

City, State:_____ **Zip:**_____

Home Phone:_____ **Work Phone:**_____

Cell Phone:_____ **Marital Status:**_____

Referring Doctor:_____

Medical Doctor:_____

Address:_____

Phone:_____

Other Important Specialists:_____

Pharmacy Name and Phone Number:_____

Employer Name:_____

Address:_____

PRIMARY INSURANCE

Medicare#_____

Other Insurance

Company Name_____

Cardholder Name_____ D.O.B._____

ID#_____ Group#_____

SECONDARY INSURANCE

Company Name_____

Cardholder Name_____ D.O.B._____

ID#_____ Group#_____

TYPE OF CLAIM

Regular Medical_____ Auto Accident_____

Workmans Comp_____ Legal_____

Date of Accident_____ Claim Number_____

Insurance Company Name_____

Address_____

ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION

I hereby authorize any Medicare and/or other Insurance benefits for services furnishes be paid direct to Marc Mandel, M.D. I also agree to accept financial responsibilities for all non-covered services and pay outstanding balances upon receipt of a Monthly statement. I authorize the physician to release to the Centers for Medicare/Medicaid/Insurance Carrier and/or its Agents any information required in the processing of all submitted claims. A copy of this signature is valid and original.

Signed:_____ Date:_____