



**PLEASE READ CAREFULLY & FILL OUT COMPLETELY**

**PATIENT INFORMATION**

Today's Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_  
Last First Middle

Home Address: \_\_\_\_\_  
Street or PO Box City State Zip

Home Phone: \_\_\_\_\_

SS#: \_\_\_\_\_ Marital Status:  M  D  S  W Sex: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_

How were you referred to Dr. Gill: (check one please)  
 Phone Book  Friend  Another  Dr.  Other

If referred by a doctor, please give dr.'s full name and address: \_\_\_\_\_  
Street or PO Box City State Zip

\*\* If you are a student and living away from home, please complete the following:

Parent/Guardian's Name: \_\_\_\_\_

Their Address: \_\_\_\_\_  
Street or PO Box City State Zip

**Employment Information of Primary Insured**

Employer: \_\_\_\_\_  
Employer Address: \_\_\_\_\_  
Street or PO Box City State Zip

Employer Phone: ( ) \_\_\_\_\_  
Name of Employee if other than yourself: \_\_\_\_\_

**Primary Insurance Information**

Insurance Carrier: \_\_\_\_\_  
Insured's Name: \_\_\_\_\_  
Last First Middle

Insured's Address: \_\_\_\_\_  
Street or PO Box City State Zip

Insured's SS#: \_\_\_\_\_ Insured's Date of Birth: \_\_\_\_\_  
Insured's Sex:  Male  Female

Patient's Relationship to Insured: \_\_\_\_\_

## Employment Information of Secondary Insured

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Employer Address: \_\_\_\_\_  
Street or PO Box City State Zip  
Employer Phone: ( ) \_\_\_\_\_  
Name of employee if other than yourself: \_\_\_\_\_

## Secondary Insurance Information

Insurance Carrier: \_\_\_\_\_  
Insured's Name: \_\_\_\_\_  
Last First Middle  
Insured's Address: \_\_\_\_\_  
Street or PO Box City State Zip  
Insured's SS#: \_\_\_\_\_ Insured's Date of Birth: \_\_\_\_\_  
Insured's Sex:  Male  Female  
Patient's Relationship to Insured: \_\_\_\_\_

Name of person to contact in case of emergency. \*\* Please list someone who does not live with you: \_\_\_\_\_  
Contact Person's Phone: ( ) \_\_\_\_\_  
Their Relationship to You: \_\_\_\_\_

\*\* If you have a medicare card, please sign your name below exactly as it is on your medicare card: \_\_\_\_\_

\*Payment is due at the time of service. Unless previous arrangements have been made, please pay all co-pays at the window after your office visit. It is the responsibility of the patient to know if their insurance requires them to have a referral from their primary care physician before seeing any specialists. If a referral is required and not brought in at the time of they visit, the patient may call their PCP and ask the referral be faxed to our office or they may reschedule their appointment in order to get the referral. We appreciate your cooperation.

\*\* I authorize the release of any medical information necessary to process all insurance claims.

Patient's signature \_\_\_\_\_  
Guardian's signature for minors \_\_\_\_\_  
Relationship to patient \_\_\_\_\_  
Date: \_\_\_\_\_