BRIAN BEZACK, DO, PLLC

Pediatric Pulmonary Medicine

PATIENT INFORMATION

Last Name:	First Name:	Middle Initial:
Gender: □ Male □ Female	Date of Birth:	
Parent 1:	Mobile #:	Work #:
Parent 2:	Mobile #:	Work #:
Home #:	Email:	
Preferred Method of Contact (where we can leave confidential information): *PLEASE CHOOSE ONE*	□ Home □ Mobile – Parent 1 □ Work – Parent 1 □ Mobile – Parent 2 □ Work – Parent 2	
Current address:		
City:	State:	Zip Code:

PEDIATRICIAN/PRIMARY CARE PHYSICIAN

First and Last Name:	Phone Number:

AUTHORIZED INDIVIDUALS

Please list any adult (other than a parent) you authorize to take your child to their appointments:	

PRIMARY INSURANCE

Plan Name:		
Primary Subscriber:	Primary Subscriber's Date of Birth:	
Patient's ID Number:	Group Number:	
Effective Date:	Patient's Relationship to Subscriber: □ Self □ Dependent	
Current address (if different from patient's):		
City:	State:	ZIP Code:

SECONDARY INSURANCE

Plan Name:		
Primary Subscriber:	Primary Subscriber's Date of Birth:	
Patient's ID Number:	Group Number:	
Effective Date:	Patient's Relationship to Subscriber: □ Self □ Dependent	
Current address (if different from patient's):		
City:	State:	ZIP Code:

AUTHORIZATION

I hereby authorize direct payment of medical benefits to Brian Bezack, D.O., for services rendered. I understand that I am financially responsible for any balance not covered by my insurance. I authorize the release of any medical information necessary to process my insurance claim.

Signature of Patient or Legal Guardian:	Date:
Print Name of Patient or Legal Guardian:	