LAUREL ENDOCRINE & Thyroid Specialists, PA

J. ROBERT BRENNAN, MD · ERIC HORST, MD · MARJAN KAREGAR, MD · LAURA LABOONE, MD
JANELLE HINSON, PA-C · APRIL INABINET, FNP · MEAGAN COCKFIELD, FNP

ACCOUNT # _____ DATE _____

PATIENT'S NAME _____ DATE OF BIRTH _____-_____-_____ AGE _____ M/F

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Cell Phone _____

EMERGENCY CONTACT _____ PHONE NUMBER _____

Patient's SSN _____ Referring Physician _____

Married _____ Separated _____ Widow(er) _____ Single _____ Divorced _____

Employer _____

Email _____

PHARMACY _____ PHARMACY PHONE NUMBER _____

PRIMARY INSURANCE CO _____ POLICY ID # _____

Name of Insured _____ Date of Birth _____

Relation to Patient _____ SSN _____

SECONDARY INSURANCE CO _____ POLICY ID # _____

Name of Insured _____ Date of Birth _____

Relation to Patient _____ SSN _____

Employer _____ Group Number _____

AUTHORIZATION OF RELEASE OF MEDICAL INFORMATION TO: LAUREL ENDOCRINE AND THYROID SPECIALISTS, P.A.

J. Robert Brennan, M.D. Eric Horst, M.D. Marjan Karegar, M.D. Laura LaBoone, M.D. Janelle Hinson, P.A. April Inabinet, NP Meagan Cockfield, NP

I authorize Laurel Endocrine and Thyroid Specialists, P.A. to obtain any medical information needed from any physician or hospital.

Patient Signature _____

ASSIGNMENT OF INSURANCE BENEFITS

I request payment of medical benefits be made to Laurel Endocrine and Thyroid Specialists, P.A. or their physicians for services rendered to me.

I UNDERSTAND THAT IN THE EVENT MY INSURANCE DOES NOT PAY, I AM RESPONSIBLE FOR PAYMENT IN FULL.

I AUTHORIZE LAUREL ENDOCRINE AND THYROID SPECIALISTS, P.A. TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION OR ITS INTERMEDIARIES ANY INFORMATION NEEDED FOR THIS CLAIM OR A RELATED MEDICARE/INSURANCE CLAIM. I permit this authorization or a photostatic copy of the original to be used and request payment of medical benefits be made to Laurel Endocrine and Thyroid Specialists, P.A.

Patient Signature _____ **Date** _____