ROBERT J. LEE, M.D.
PATIENT INFORMATION

Referring Dr. _____ Date:_____
Patient's Last Name: _____ First: _____ Middle:_____
Mailing Address: _____
Street City State Zip
Home Phone: _____ Cell Phone:_____
Patient's SSN: _____Patient's Age: _____ Patient's Birthdate: _____
Patient's Employer: _____ Occupation: _____
Address: _____ Work Phone: _____
Sex: __Male __Female Marital Status: __Single __Married __Divorced __Widowed

SPOUSE/GUARDIAN INFORMATION

Name of Spouse/Guardian: _____ SSN: _____
Address: _____
Street City State Zip
Place of Employment: _____ Occupation: _____
Work Number: _____ Date of Birth:_____
Notify in Case of Emergency: _____ Phone: _____

INSURANCE INFORMATION

Place of Injury: __Work __Home __School __Auto __Farm __Other
What was the date of injury or onset of symptoms: _____Third Party Liability_____
How did the injury occur?:_____

PRIMARY Insurance Company: _____ Group No._____
Address:_____ Phone No._____
Name of Policy Holder: _____ Policy No._____
Policy Holder's SSN:_____ Policy Holder's DOB: _____
Patient's Relationship to Policy Holder:_____

SECONDARY Insurance Co.:_____ Group No._____
Address:_____ Phone No._____
Name of Policy Holder: _____ Policy No._____
Policy Holder's SSN:_____ Policy Holder's DOB: _____
Patient's Relationship to Policy Holder:_____

INFORMATION RELEASE

I hereby authorize Dr. Robert J. Lee to release any information acquired in the course of my examination or treatment to the Insurance carriers. I hereby authorize any physician, hospital, or medical care facility to provide all information on my medical history and treatment to Dr. Robert J. Lee.
Please Read & sign below

I AUTHORIZE DR. ROBERT J. LEE TO RECEIVE ASSIGNMENT OF INSURANCE PAYMENTS. IF THE CUSTOMARY CHARGES ARE MORE THAN THE BENEFITS ALLOWED UNDER RESPONSIBLE PARTY'S INSURANCE PLAN, I AGREE TO PAY THE DIFFERENCE. I UNDERSTAND THAT REGARDLESS OF INSURANCE COVERAGE I AM REPONSIBLE FOR ALL CHARGES AND PAYMENTS. I FUTHER UNDERSTAND THAT MISSED APPOINTMENTS WHICH ARE NOT CANCELED IN ADVANCE WILL BE CHARGED A FLAT FEE OF $15 AND THAT THIS FEE IS NOT PAYABLE BY MY INSURANCE COMPANY. A 12% ANNUAL INTEREST RATE WILL BE CHARGED FOR OUTSTANDING BALANCES AFTER 90 DAYS.

I further authorize the doctor's office to make photocopies of this authorization and assignment, in order for them to attach a copy to any insurance form and to be able to retain the original copy in the doctor's files and authorize the insurance company to accept the photocopy. I release you from all legal responsibility or liability that may arise from this authorization. This authorization shall continue and be in force and effect until revoked in writing by me.

_____
RESPONSIBLE PARTY'S SIGNATURE DATE