Timothy F. Murphy M.D. OB/GYN

913 E. Ludington Ave. • Ludington, MI 49431 • (231) 425-4747

PATIENT INFORMATION

Patient's Full Name: _____
LAST FIRST MIDDLE MAIDEN

Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ Social Security #: _____

Employer: _____ Occupation: _____ Work Phone: _____

PLEASE CHECK ONE: ☐ Spouse ☐ Parent Name: _____

Spouse/Parent Date of Birth: _____ Phone Number: _____ Social Security #: _____

Emergency Contact: _____ Relationship: _____ Phone: _____
OTHER THAN SPOUSE/PARENT LISTED ABOVE

REFERRAL INFORMATION

Please tell us how you heard about us or who referred you here: _____

INSURANCE INFORMATION

Do you have insurance? ____Yes ____No *(We ask all patients to show their insurance card so that we may make copies of them)*

Are you covered by Medicaid? ____ Yes ____ No Medicaid ID#: _____

Are you covered by Medicare? ____ Yes ____ No Medicare #: _____

Railroad Medicare? _____

Primary Insurance Carrier: _____ Group #: _____

Identification/Policy #: _____ Subscriber Name: _____

Secondary Insurance Carrier: _____ Group #: _____

Identification/Policy #: _____ Subscriber Name: _____

We cannot render services on the assumption that our charges will be paid by an insurance company. All services are the patient's responsibility. As a courtesy, however, we willl prepare any necessary reports and itemizations to assist in making collections from insurance companies and will credit any such collections to the patient's account.

PAYMENT AUTHORIZATION

I request payment of authorized benefits to be made to Timothy F. Murphy MD, PC, on my behalf for services furnished me. I authorize any holder of medical or other information about me to release to my insurance company and its agents any information needed to determine these benefits for related services. Although covered by insurance. I am aware that I am personally responsible for all charges.

Patient Signature: _____ Date: _____