WELCOME TO OCEAN MEDICAL

Account #

version 032113

PATIENT INFORMATION (Please Answer All Questions Legibly)

NAME (Last, First, Middle Initial)	Birthdate	Age	Social Security #

Sex: Male _____ Female _____ | Marital Status: Single _____ Married _____ Divorced _____ Widowed _____ Separated _____

Home Street Address (P.O. Boxes are NOTacceptable)

City	State	Zip Code	Home Phone #

Driver's License #	Cell #	Email	If Visiting From Out of Town, Local Phone # and Address

PATIENT'S EMPLOYMENT INFORMATION - IF STUDENT, NAME OF SCHOOL

Name of Employer or School	Occupation

Employer Address

City	State	Zip Code	Work Phone #

FINANCIALLY RESPONSIBLE PARTY - IF SAME AS PATIENT CHECK HERE ☐ IF DIFFERENT THAN PATIENT COMPLETE THIS SECTION

NAME (Last, First, Middle Initial)	Birthdate	Age	Social Security #

Home Street Address (P.O. Boxes are NOTacceptable)

City	State	Zip Code	Home Phone #

Driver's License #	Cell #	Email	If Visiting From Out of Town, Local Phone # and Address

Employer	Employer Street Address		

City	State	Zip Code	Work Phone #

Method of Payment Cash _____ Check _____ Credit Card _____ Travelers Check _____

PRIMARY INSURANCE INFORMATION

Name of Primary Insurance Company	Insured's Name (Last, First, Middle Initial)		Insured's Social Security #
Group #	Subscriber #	Insured's Birthdate	Do you have a Prescription Plan?
Annual Deductible Amount	Has PATIENT'S deductible been met for this year?	Co-Payment amount	Insurance Benefit (e.g. 80/20)

SECONDARY INSURANCE INFORMATION - OCEAN MEDICAL DOES NOT ACCEPT HMO PLANS AS SECONDARY INSURANCE

Name of Secondary Insurance Company	Insured's Name (Last, First, Middle Initial)		Insured's Social Security #
Group #	Subscriber #	Insured's Birthdate	Do you have a Prescription Plan?
Annual Deductible Amount	Has PATIENT'S deductible been met for this year?	Co-Payment amount	Insurance Benefit (e.g. 80/20)

REFERRAL INFORMATION

_____ Doctor: _____ _____ Internet _____ Employer

Phone #: _____ _____ Yellow Pages _____ Sign on Building

_____ Friend/Family _____ Other: _____

Emergency Contact Name (Last, First, Middle Initital	Phone #	Relationship

FINANCIAL AGREEMENT - READ BEFORE SIGNING

I Understand That Fees Are Payable When Service Is Rendered Unless Prior Arrangements Have Been Made. I Understand That I Am Financially Responsible For All Charges Whether Or Not Covered By Insurance. Payment For Services Rendered To Me And/Or My Dependents Will Not Be Delayed Or Withheld Because Of Pending Insurance Claims. I Understand That I Am Financially Responsible For Any Collection Agency Costs Or Legal Costs Resulting From Any Delays. I Authorize Payment of Medical Benefits To Ocean Medical Provider of Services.

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY CLAIM.

Signature _____ Date _____ Relationship to Patient _____

Received By:	Entered By:	Date Entered: