**BAMBERG FAMILY PRACTICE Practice Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**F. Marion Dwight, MD, PA**

**PATIENT INFORMATION**

Name: Date of Birth:

Mailing Address: Social Security No:

City: Patient Employer:

State: Zip: Employer Address:

Home Phone: Work Phone:

Cell Phone: E Mail:

Race: Sex: Marital status:

**RESPONSIBLE PARTY INFORMATION**

Name: Date of Birth:

Mailing Address: Social Security No:

City: Relationship to Patient:

State: Zip: Employer:

Home Phone: Employer Address:

Work Phone: Cell Phone:

**INSURANCE INFORMATION**

Primary Insurance: Secondary Insurance:

ID#: ID#:

Group Number: Group Number:

Address: Address:

Subscriber Name: Subscriber Name:

Subscriber Date of Birth: Subscriber Date of Birth:

Relationship to patient: Relationship to patient:

Social Security No.: Social Security No.:

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION FOR PAYMENT AND TREATMENT**

I authorize F. Marion Dwight, MD, PA to release any information (including medical information) for insurance or third party payer claim submissions and/or payment for services. I also authorize that benefits from the insurance company of any third party payer be paid directly to F. Marion Dwight, MD, PA. I guarantee payment in full to F. Marion Dwight, MD, PA for the amount due for treatment rendered.

I authorize the release of my personal medical information for the purpose of providing, coordination, and managing my health care. This includes the coordination of management of my health care with a third party such as another physician or health care agency.

I do hereby voluntarily consent to such diagnostic procedures, hospital care and medical, surgical treatment by F. Marion Dwight, MD, PA physician(s), physician assistants, nurse practioners, or physician’s designees as is necessary in his/her judgement. I acknowledge that no guarantees have been made to me as the result of treatments or examinations in the facility.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_