Patient's
Last name : _____ First name : _____ MI : ____

Address : _____

City : _____ State code : ____ Zipcode : _____

Referring Dr:
Phone # : _____ Sex (M/F) : ____ Marital : Status : ____ S M D W

Birthday : _____/_____/_____ Social sec : _____/_____/_____

Home Phone : (_____)_____ Work Phone : (_____)_____

Emergency : _____ Emer Phone : (_____)_____

Email : _____ Cell Phone : (_____)_____

Language : _____ Race : _____ Ethnicity : _____

== Primary Insurance Coverage ======== == Secondary Insurance Coverage ========

Company : _____ Company : _____

Insured name : _____ Insured name : _____

Relationship : _____ DOB:_____ Relationship : _____ DOB:_____

Co-pay amount : _____ Co-pay amount : _____

Policy number : _____ Policy number : _____

Group number : _____ Group number : _____

Employer : _____ Employer : _____

== Guarantor Information ==========

Guarantor : _____

Address : _____

City : _____ State code : _____ Zipcode : _____

Telephone # : (_____)_____ Miscellaneous : _____

Patient's Authorization

I authorize JEFFREY D. HOROWITZ, M.D. LLC to apply for benefits on my behalf for services rendered by JEFFREY D. HOROWITZ, M.D. LLC. I request payment from my insurance company be made directly to JEFFREY D. HOROWITZ, M.D. LLC. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claims. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time in writing. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for medical services provided, when a statement is rendered.

_____ _____

Signature of Subscriber or Beneficiary Date