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Welcome to the office of Dr. Richard Uhler. Please take the time to **complete all** of the attached forms. Even though copies of insurance and identification cards are required, we ask you to complete the information in full. We bill your insurance as a courtesy to you. We are unable to bill insurance companies without the following information. If you have any questions, please feel free to ask for assistance.

HEALTH INFORMATION FORM

PATIENT INFORMATION (Please write clearly)

Patient Name: ________________________________SSN:________________ Age: _______

Birth Date: ____/____/____ Sex: M F Phone: _____________ □Married □Single □Widow □ Divorced

Address: ___________________________________ City: __________ State: ____ Zip: _________

Email address: ______________________________Race: ______________Ethnicity:______________

Emergency Contact: __________________________ Relationship: __________Phone:____________

□ Employed □ Student: □ F/Time □ P/Time Employer or School Name: _______________________

Reason for Visit: _______________________ Referred by: _______________ Date Of injury:_______

Pharmacy used for medications: _________________________ Location: ________________________

NAME OF PERSON WHOSE INSURANCE IS BEING BILLED

Relationship of Patient: Child Self Spouse Other (Circle One) Phone: _________________

Name: ______________________________________ SSN: ________________________________

Birth Date: _____/_____/_____ Sex: M F Drivers License No. __________________

Address: ________________________________City: ____________ State: _____ Zip:_________

Employer: _____________________________________ Phone: ____________________________

Employer Address: __________________________City: _____________ State: ______ Zip: ______

PRIMARY INSURANCE INFORMATION (List all information according to insurance card)

Insured's Name: __________________________ SSN: _________________Birth Date: ___/____/____

Insurance Name: __________________________________ Type of Insurance: PPO POS EPO Other:

ID Number: _______________________ Group No. _______________Effective Date: /____/____/____

SECONDARY INSURANCE INFORMATION (List all information according to insurance card)

Insured's Name: ___________________________SSN: ____________Birth Date: ___/____/____

Insurance Name: __________________________________Type of Insurance: PPO POS EPO Other:

ID Number: ______________________ Group No. _________________ Effective Date: ____/____/____

SIGN AND DATE

I declare the above information to be true and correct. I understand I am financially responsible for any amounts not paid by my insurance.

Signature of Patient/Insured/Guarantor__________________________________Date: _______________