

CARL W. LENTZ, III, M.D., F.A.C.S.
PATIENT INFORMATION SHEET

PLEASE PRINT

TODAY'S DATE _____ E-MAIL _____

NAME _____ SOC. SEC.# _____ AGE _____ DOB _____

ADDRESS _____ CITY _____

STATE _____ ZIP _____ HOME TELEPHONE (_____) _____ CELL PHONE (_____) _____

PLACE OF BIRTH _____ SINGLE ___ MARRIED ___ DIV/SEP ___ WIDOWED SEX: ___ MALE ___ FEMALE

DRIVER'S LICENSE # _____ STATE _____ EXPIRATION _____

OCCUPATION _____ WORK TELEPHONE # (_____) _____

PLACE OF EMPLOYMENT _____

WORK ADDRESS _____

SPOUSE'S NAME (SIGNIFICANT OTHER) _____ WORK TELEPHONE # (_____) _____

SPOUSE'S PLACE OF EMPLOYMENT _____

WORK ADDRESS _____

NEAREST RELATIVE (NOT LIVING WITH YOU) _____

NEAREST RELATIVE'S ADDRESS _____

NEAREST RELATIVE'S TELEPHONE (_____) _____ REFERRED BY _____

PERSON TO CONTACT IN EMERGENCY _____ PHONE (_____) _____

PRIMARY PHYSICIAN _____ PHONE (_____) _____

ADDRESS _____

Written consent must be given if information is to be provided to anyone else (ie. spouse). Verbal information regarding my condition may be given to: _____ relationship _____

DO YOU HAVE MEDICAL INSURANCE ___ YES ___ NO

PRIMARY INSURANCE CARRIER _____

NAME OF INSURED _____ MEMBER ID # _____

GROUP # _____ BIRTH DATE OF INSURED _____

EMPLOYER _____ SS# OF INSURED _____

RELATION TO INSURED _____ MAILING ADDRESS OF CLAIMS _____

SECONDARY INSURANCE CARRIER _____

NAME OF INSURED _____ MEMBER ID # _____

GROUP # _____ BIRTH DATE OF INSURED _____

RELATION TO INSURED _____ MAILING ADDRESS OF CLAIMS _____

IF PATIENT IS UNDER 18 OR IF COVERED UNDER YOUR PARENT'S INSURANCE:

INSURED PARENT'S NAME _____ PHONE (_____) _____

PLACE OF EMPLOYMENT _____

ADDRESS _____

CONSENT TO CARE: I present myself to Carl W. Lentz, III, M.D. for medical care. I hereby authorize and consent to such care, including any tests, examinations, diagnostic procedures, surgical & medical treatment or other care which my doctor feels is necessary and beneficial to me. No guarantees have been made to me about the outcome of this care. I authorize Carl W. Lentz, III, M.D., to take photographs in conjunction with my medical condition & treatment to be maintained in my file. I also authorize that these photographs may be used for teaching and/or publication.

CONSENT TO THE ASSIGNMENT OF INSURANCE BENEFITS AND GUARANTEE OF PAYMENT FOR SERVICES:

I request payment of authorized insurance benefits (health, casualty or other) including Medicare benefits, due for any services furnished by Carl W. Lentz, III, M.D., be made to the provider. I assign the benefits payable for physician services to the physician or organization furnishing the service or authorize such physician or organization to submit a claim to my insurance company for payment to me. I authorize any holder of medical or other information about me to release to the insurance company or its intermediaries or carriers any information for this or future claims. I understand I may receive billing for services performed by outside facilities, laboratories, etc. I hereby authorize Carl W. Lentz, III, M.D. to apply any payments made by me and/or on my behalf by a third party payor toward the account referenced. I understand I am responsible for, and agree to pay, upon presentation or demand, any charges that are my responsibility not covered or not paid by any applicable insurance. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for all professional services rendered.

I have read all of the information on this form and have answered the questions. I hereby certify that all information is true and correct to the best of my knowledge. I will notify Carl W. Lentz, III, M.D. of any changes in my health status or the above information.

SIGNATURE _____ DATE _____

SIGNING AS (please check one) ___ PATIENT ___ GUARDIAN ___ GUARANTOR