Date:

GUARANTOR'S INFORMATION:

Last Name_____ First _____Middle _____

Mailing Address_____ City_____ St _____ Zip _____

Primary Phone # (_____) _____ Secondary Phone # (_____) _____

Date of Birth _____ / _____ / _____ Social Security # _____ Driver's License # _____

Marital Status: _____ Married _____ Single _____Widow(er) _____ Divorced _____ Separated

Full Time Student: _____ Yes _____ No School Name _____

Employer _____Employer's Phone # _____

Employer's Address _____ City_____ St_____ Zip _____

Name of Spouse (if Applicable) _____Date of Birth _____

Spouse's Employer_____ Spouse's Phone # _____

Employer's Address _____City_____ St _____ Zip _____

PATIENT INFORMATION: (If Different From Guarantor's Information)

Last Name_____ First _____Middle _____

Address_____ City_____ St _____ Zip _____

Home Phone # (____) _____ Work Phone # (____) _____ Ext. _____ Cell # (____)_____

Date of Birth _____ / _____ / _____ Social Security # _____ Driver's License # _____

Marital Status: _____ Married _____ Single _____Widow(er) _____ Divorced _____ Separated

Full Time Student: _____ Yes _____ No School Name _____

Employer _____Employer's Phone # _____

Employer's Address _____ City_____ St_____ Zip _____

Name of Spouse (if Applicable) _____Date of Birth _____

PEOPLE WE MAY DISCUSS YOUR HEALTH INFORMATION WITH:

1. _____ Phone # _____

2. _____ Phone # _____

3. _____ Phone # _____

AUTHORIZATIONS

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered by Richard D. Jelsma, M.D. either in the office or in the hospital. I request my insurance company to make benefits payable directly to Richard D. Jelsma, M.D., P.A. This is a direct assignment of my rights and benefits under this policy. I authorize the release of any medical information necessary to process my insurance claims. If the patient is a minor, I hereby give my consent to Richard D. Jelsma, M.D. to render both emergency and non-emergency healthcare services both in and out of my physical presence. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

Signature of Patient / Legal Guardian: _____ Date:_____