Helen Stosel M.D.

PATIENT INFORMATION

Name:	Date of Birth
Address One:	Social Security #
Address Two:	Sex:
City	Language:
State:	Employer:
Home Phone #:	Emergency Contact:
Work Phone#:	Emergency Phone#:
Cell Phone#:	Emergency Relationship:

GUARANTOR INFORMATION

Name:	Date of Birth
Address One:	Social Security #
Address Two:	
City	Employer:
State:	Employer Address:
Home Phone #:	Address Two:
Work Phone#:	Employer City:
Cell Phone#:	Employer State:

GUARANTOR INFORMATION

Primary Insurance:	Secondary Insurance:
Certificate#:	Certificate#:
Group Number:	Group Number:
Group Name:	Group Name:
Copay:	Copay:
Subscriber Name:	Subscriber Name:

Authorization To Pay Benefits To Physician: I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to myself or to my Provider, Helen Stosel M.D. when she accepts assignment.

Authorizations To Release Medical Information. I hereby authorize my Provider, Helen Stosel M.D. to release any information necessary for my course of treatment

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Signed (patient or parent if minor). Date