

**Patient Check In**

*Please review the information below that we currently have in our records. Mark out any incorrect information or changes and fill in any blanks. Notify our staff so that we may make these changes in our system. Thank you.*

**Full Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **SSN:** \_\_\_\_\_

**Billing Address:** \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_

**Current Medications:** \_\_\_\_\_

**Drug Allergies:** \_\_\_\_\_

**Provide the following if guarantor is different than patient:**

**Guarantor:** \_\_\_\_\_

Guarantor's SSN: \_\_\_\_\_ DOB: \_\_\_\_\_

**Primary Insurance:** (please circle one) PPO HMO Other Unsure

Patient's relationship to insured: \_\_\_\_\_

**Secondary Insurance:** (please circle one) PPO HMO Other Unsure

Show card to receptionist.

Patient's relationship to insured: \_\_\_\_\_

**Name of Physician that referred you to our office:** \_\_\_\_\_

**Name of Physician that is your PCP or primary care physician:** \_\_\_\_\_

Has any member(s) of your family been treated at this office? YES NO UNSURE

I plan to make payment of my medical expenses as follows (please circle one or more):

CASH/CHECK MC/VISA AMER EXPRESS DISCOVER

I authorize G. DeAn Strobel, M.D., P.A. to release medical information that may be necessary to request reimbursement from insurance companies to whom I have submitted a claim. I understand that I am responsible for all medical fees during my treatment at G. DeAn Strobel, M.D., P.A.

If surgery is required, I assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, to G. DeAn Strobel M.D., P.A..

I also certify that the above information is correct to the best of my knowledge.

\_\_\_\_\_  
Patient/Guarantor/Guardian Signature

\_\_\_\_\_  
Date