

The Bridge Medical Center
Insurance and Billing Information

Which doctor are you scheduled to see? (circle one) Dr. Cole / Dr. Gordon / Dr. _____

LAST NAME: _____ FIRST _____ MI _____ DOB: ____ / ____ / ____

Home Address: _____

Mailing Address (if different) _____

City: _____ State: _____ Zip: _____

PHONE: Home- _____ Work- _____ Cell- _____

SOCIAL SECURITY #: _____ - _____ - _____

GENDER: M / F MARITAL STATUS: Single / Married / Div or Sep / Widowed

SPOUSE OR GUARANTOR NAME (if other than patient): _____

Address: _____ PH#: (____) _____

SS#: _____ - _____ - _____ DOB: ____ / ____ / ____

PATIENT'S EMPLOYER NAME: _____ WK Phone #: (____) _____

COMPANY NAME: _____ Occupation: _____

IS YOUR VISIT WORKERS COMP OR AUTO ACCIDENT RELATED? YES / NO

*If yes complete:

INSURANCE: _____ ADDRESS: _____

DATE OF INJURY: ____ / ____ / ____ CLAIM# _____ ADJUSTOR _____

(If insurance card has been copied, please only complete each insurance company name)

PRIMARY INSURANCE NAME: _____ SS# _____ DOB _____

SECONDARY INSURANCE: _____

EMERGENCY CONTACT (PERSON WHO DOES NOT LIVE WITH YOU)

Name: _____ PH# _____ City/State _____

Relationship to Patient: _____

CONSENT FOR MEDICAL TREATMENT AND PAYMENT AGREEMENT

I HEREBY CONSENT TO MEDICAL TREATMENT UNDER THE CARE OF Patricia Cole, MD or Steven K. Gordon, ND. I agree to pay for all medical services rendered, whether they are covered by my insurance or not. I authorize the release of medical records to ensure payment of claims. I understand that I am responsible for any deductible, co-payments, or denials from my insurance. I realize it is ultimately my responsibility to be sure the doctor receives payment no later than ninety (90) days after date of service.

X _____

Date _____

(Patient, Guarantor, or Parent/Guardian Signature)