

# Patient Profile

Doctor: Allison L. McCormick, MD

## PATIENT INFORMATION

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State: \_\_\_\_\_  
Phone: \_\_\_\_\_  Home  Work  Other  
Phone: \_\_\_\_\_  Home  Work  Other

## PATIENT EMPLOYMENT

Employed  Retired  Unemployed  Other  
Phone: \_\_\_\_\_  
Employer: \_\_\_\_\_

## GUARANTOR

Same as Patient  
Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State: \_\_\_\_\_

## PRIMARY INSURANCE

Same as Patient  Same as Guarantor  Other  
Insured Party: \_\_\_\_\_  
Insured's Phone: \_\_\_\_\_  
Company: \_\_\_\_\_

## SECONDARY INSURANCE

Same as Patient  Same as Guarantor  Other  
Insured Party: \_\_\_\_\_  
Insured's Phone: \_\_\_\_\_  
Company: \_\_\_\_\_

Patient ID #: \_\_\_\_\_  
Sex:  M  F  
Date of Birth: \_\_\_\_\_  
Social Security #: \_\_\_\_\_  
Marital Status:  Married  Single  Divorced  
Referring Physician: \_\_\_\_\_  
Primary Physician: \_\_\_\_\_

## CONTACTS

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## EMPLOYMENT

Employer: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Social Security #: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_  
Social Security #: \_\_\_\_\_  
Insured ID #: \_\_\_\_\_  
Policy Group: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_  
Social Security #: \_\_\_\_\_  
Insured ID #: \_\_\_\_\_  
Policy Group: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_

## ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with \_\_\_\_\_  
(Name of Insurance Company)

and assign directly to Dr. Allison L. McCormick all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature of Insured/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_