William B. Cobb, M.D., P .A.
Ewen Y Tseng, M.D., P.A.

Keith E. Matheny, M.D.

● ●THIS FORM NEEDS TO BE COMPLETED IN FULL ● ●

PATIENT INFORMATION **DATE:** _____/_____/_______

If your insurance coverage requires a referral, it is your responsibility to obtain this **before** your appointment time, otherwise we are required to reschedule this appointment. When registering, please present proof of insurance, Medicare and/or Medicaid and your driver's license.

Patient Information

Full Legal Name___________________________________ Birthdate ________________ Age ________ Sex ________

Address __________________________________ City ____________________ State ________ Zip _____________

(Mailing address)

Phone (home) ________________________ Work ____________________ Single Married Divorced Widowed

Driver's License # ______________________________ Social Security #_________ - _______-______________

Employer _____________________________________ Occupation ______________________________________

Insurance Information of Insured

Name of Insured _______________________ Date of Birth ________ Relationship to Patient __________________

Address __________________ City _____________ State _____ Zip ________ Phone #_____________

Social Security # ____

Employer ________________________________Work Phone # ______________ Occupation ____________________

Name of Insurance Company ____ Phone # _____________________

Address (For Claims) ____

City ____State ________Zip ____________________________

Member ID # ____ Group # ____________________________________

Spouse / Guardian

Name _________________________________Date of Birth__________ Relationship to Patient _________________

Address ____________________ City _____________ State________ Zip ___________ Phone # _________________

Employer ____Work Phone #_____________________________

Have you or any member of your immediate family been seen in this office before?

Yes ___________ No ___________ Name(s) ____

Primary Physician: ____ Phone # _________________________________

Referring Physician: ____Phone # _________________________________

Address ____

NAME OF SOMEONE TO CONTACT IN CASE OF AN EMERGENCY:____

RELATIONSHIP: ______________ HOME PHONE: (____) _____-_________ WORK PHONE: (____) _____-_________

● ● OV ER ● ●

AUTHORIZATION TO RELEASE PATIENT INFORMATION

I AUTHORIZE WILLIAM COBB, MD./EWEN TSENG, MD./ KEITH MATHENY, MD. TO RELEASE AND FURNISH ON A CONFIDENTIAL AND A STRICT NEED TO KNOW BASIS ALL MEDICAL AND FINANCIAL DATA RELATED TO MY CARE THAT MAY BE NECESSARY NOW OR IN THE FUTURE TO FACILITATE PAYMENT BY THIRD PARTIES FOR SERVICES RENDERED BY PHYSICIAN, OR TO ASSIST WITH, AID IN, OR FACILITATE THE COLLECTION OF DATA FOR PURPOSES OF UTILIZATION REVIEW, QUALITY ASSURANCE, OR MEDICAL OUTCOMES EVALUATION PURPOSES. SUCH INFORMATION MAY BE RELEASED TO INSURANCE COMPANIES, HMO'S, PPO'S, MANAGED CARE ORGANIZATIONS, INDEMNITY PLANS, MEDICARE/MEDICAID OR OTHER GOVERNMENTAL OR THIRD PARTY PAYERS, OR ANY ORGANIZATIONS CONTRACTING WITH ANY OF THE ABOVE ENTITIES TO PERFORM SUCH FUNCTIONS.
I ALSO GIVE MY AUTHORIZATION TO HAVE A COPY OF MY MEDICAL RECORDS DELIVERED TO A PRIMARY CARE PHYSICIAN OR ANY OTHER PHYSICIAN THAT IS DIRECTLY OR INDIRECTLY RESPONSIBLE FOR MY MEDICAL CARE OR THE PAYMENT THEREOF.

PATIENT'S SIGNATURE ____

PATIENT'S RESPONSIBILITY

SIGNING OF THIS FORM IN NO WAY IMPLIES THAT YOUR VISITS WITH THIS OFFICE WILL, BE COVERED BY YOUR INSURANCE COMPANY. WILLIAM COBB, MD./EWEN TSENG, MD./ KEITH MATHENY, MD. AND THEIR EMPLOYEES CANNOT GUARANTEE ANY INFORMATION GIVEN TO US BY YOUR INSURANCE CARRIER REGARDING YOUR BENEFITS.

1. IF YOU ARE NOT PART OF AN HMO, PPO, MEDICARE/MEDICAID, OR MANAGED CHOICE PLAN THAT WE PARTICIPATE IN, YOU WILL BE RESPONSIBLE FOR YOUR BILL AT THE TIME OF SERVICE.
2. IF YOU ARE PART OF A PPO PLAN AND YOU HAVE A DEDUCTIBLE FOR SERVICES OTHER THAN YOUR REGULAR OFFICE COPAY, YOU WILL BE RESPONSIBLE FOR PAYMENT OF SAID DEDUCTIBLE.
3. IF YOU ARE PART OF A MANAGED CHOICE OR HMO PLAN, FAILURE TO OBTAIN A VALID REFERRAL FROM YOUR PRIMARY CARE PHYSICIAN (PCP), MAY RESULT IN NO BENEFITS BEING PAID. YOU WILL BE RESPONSIBLE FOR ANY NON-PAYMENT FROM YOUR INSURANCE CARRIER.

PATIENT'S SIGNATURE ____

DATE ____