MARLEE ZWEIFACH, MS, RD, CDE

Date: ☐

Name: _____

Address: _____ Apt No.: _____

City: _____ State: _____ Zip: _____

Age: _____ Birth Date: _____ Sex: ☐M ☐F ☐Single ☐Married ☐Other ☐Student

Home Phone: _____ Cell Phone: _____ email: _____

Employer: _____ Bus Phone: _____

Primary Care Physician: _____ Physician Phone: _____

Emergency Contact: _____ Contact Phone: _____

PRIMARY INSURANCE

Insurance Company: _____ Group#: _____ Policy#: _____

Subscriber: _____ SSN: _____

Relation to Patient: _____ Birthdate: _____

Address: _____ City: _____ State: _____ Zip: _____

(if different from patient)

Phone: _____ Alt Phone: _____ Alt Phone 2: _____

Subscriber Employed by: _____ Occupation: _____

Business Address: _____ Business Phone: _____

ADDITIONAL INSURANCE

Insurance Company: _____ Group#: _____ Policy#: _____

Subscriber: _____ SSN: _____

Relation to Patient: _____ Birthdate: _____

Address : _____ City: _____ State: _____ Zip: _____

(if different from patient)

Phone: _____ Alt Phone: _____ Alt Phone 2: _____

Subscriber Employed by: _____ Occupation: _____

Business Address: _____ Business Phone: _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____
And assign directly to the provider all insurance benefits, if any, otherwise payable to me for services rendered. 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 insurance submissions.

_____ _____ _____

Responsible Party Signature Relationship Date