(248)544-9300

Website: www.DoctorBeWell.com

PLEASE PRINT AND COMPLETE ALL. ENTRIES Patient Name (Last, First, MI) Patient Name (Last, First, MI) Address (Street, City, State, Zip) Address (Street, City, State, Zip) Employer Name & Address Work Phone (') Email Address Work Phone (') Email Address Social Security # Spouse's Work # Name of Nearest Relative Not Living With You Emergency Contact Name Relationship Relationship Phone Number () If the Patient is a Minor, Please Provide the Responsible Party's Name and Address: How Will the Bill Be Paid Today? If Policy's Primary Insured is Other than the Patient, Please Provide Date of Birth of that Person/ I REQUEST PAYMENT OF BENEFITS TO THE PARTY WHO ACCEPTS ASSIGNMENT: Signature: Date Signed:/_/ Name:		Patient Inf	ormation Form			
Patient Name (Last, First, MI) Date of Birth Male Male Female Divorced; Domestic Partner: Widowed Address (Street, City, State, Zip) Employer Name & Address Work Phone (') Email Address Work Phone (') Email Address Spouse's Name (Last, First, MI) Name of Nearest Relative Not Living With You Phone Relationship Emergency Contact Name Relationship Relationship Relationship Phone Number (') If the Patient is a Minor, Please Provide the Responsible Party's Name and Address: How Will the Bill Be Paid Today? If Policy's Primary Insured is Other than the Patient, Please Provide Cate of Birth of that Person/ _/ IREQUEST PAYMENT OF BENEFITS TO THE PARTY WHO ACCEPTS ASSIGNMENT: Signature: Date Signed:/_/ Date Signed:/_/ Table Male Cender Male Male Phone Male Cender Male Male Phone Phone Phone Phone Phone Provide Party is Name and Address: Date Signed:/_/ TreQUEST PAYMENT OF BENEFITS TO THE PARTY WHO ACCEPTS ASSIGNMENT: Signature: Date Signed:/_/	PIT	TASE PRINT AND C	COMPT TOTAL AT I	TO THE STATE OF TH		
Employer Name & Address Work Phone (') Email Address Spouse's Name (Last, First, MI) DOB/_/ Name of Nearest Relative Not Living With You Address (Street, City, State, Zip) Emergency Contact Name Relationship Phone Number (') If the Patient is a Minor, Please Provide the Responsible Party's Name and Address: How Will the Bill Be Paid Today? If Policy's Primary Insured is Other than the Patient, Please Provide Date of Birth of that Person/ _/ I REQUEST PAYMENT OF BENEFITS TO THE PARTY WHO ACCEPTS ASSIGNMENT: Signature: Date Signed://	Patient Name (Last, First, M	Date of Birth	Age Gender Male	Marital Status Single; Married; Divorced; Domestic Partner;	Today's Date	
Spouse's Name (Last, First, MI) DOB	Address (<u>Street, City, State,</u>	Zip)	ŧ.		Social Security #	
Spouse's Name (Last, First, MI) DOB /// Name of Nearest Relative Not Living With You Address (Street, City, State, Zip) Emergency Contact Name Relationship Phone Number () If the Patient is a Minor, Please Provide the Responsible Party's Name and Address: How Will the Bill Be Paid Today? If Policy's Primary Insured is Other than the Patient, Please Provide Cate of Birth of that Person/_/ I REQUEST PAYMENT OF BENEFITS TO THE PARTY WHO ACCEPTS ASSIGNMENT: Signature: Date Signed:/_/	Employer Name & Address		Work Phone	Driver's License No.		
Name of Nearest Relative Not Living With You Address (Street, City, State, Zip) Emergency Contact Name Relationship Phone Number () If the Patient is a Minor, Please Provide the Responsible Party's Name and Address: How Will the Bill Be Paid Today? If Policy's Primary Insured is Other than the Patient, Please Provide Date of Birth of that Person/_/ I REQUEST PAYMENT OF BENEFITS TO THE PARTY WHO ACCEPTS ASSIGNMENT: Signature: Date Signed:/_/				Email Address		
Emergency Contact Name Relationship Phone Number () If the Patient is a Minor, Please Provide the Responsible Party's Name and Address: How Will the Bill Be Paid Today? If Policy's Primary Insured is Other than the Patient, Please Provide Date of Birth of that Person/ I REQUEST PAYMENT OF BENEFITS TO THE PARTY WHO ACCEPTS ASSIGNMENT: Signature: Date Signed://_	Spouse's Name (Last, First,	MI)	DOB//	Social Security #	Spouse's Work#	
If the Patient is a Minor, Please Provide the Responsible Party's Name and Address: How Will the Bill Be Paid Today? If Policy's Primary Insured is Other than the Patient, Please Provide Date of Birth of that Person / / I REQUEST PAYMENT OF BENEFITS TO THE PARTY WHO ACCEPTS ASSIGNMENT: Signature: Date Signed: _ / _ /	1	Address (Street, City, State, Zip)		Home Phone Number ()		
How Will the Bill Be Paid Today? If Policy's Primary Insured is Other than the Patient, Please Provide Date of Birth of that Person// I REQUEST PAYMENT OF BENEFITS TO THE PARTY WHO ACCEPTS ASSIGNMENT: Signature: Date Signed://	Emergency Contact Name	Relationship	· · · · · · · · · · · · · · · · · · ·	Phone Number		
If Policy's Primary Insured is Other than the Patient, Please Provide Date of Birth of that Person// I REQUEST PAYMENT OF BENEFITS TO THE PARTY WHO ACCEPTS ASSIGNMENT: Signature: Date Signed://	If the Patient is a Minor, Plea	Lse Provide the Responsibl	e Party's Name and A	Address:		
Signature: Date Signed:/_/			ease Provide Date of	Birth of that Person		
	I REQUEST PAYMENT OF BENEFITS TO THE PARTY WHO ACCEPTS ASSIGNMENT:					
Name:	Signature:			Date Signed:/	/	
	Name:					

INSURANCE

Please understand that insurance is a confract between you and your insurance company. We will be glad to assist you by submitting your claims to your insurance company. If you need to have any lab work, x-rays, or other testing, it is your responsibility to inform our office if you are required to have them done at a specific clinic or location.