AMERIGARD
DEVELOPMENT CORPORATION

Affiliated with Garden City Hospital

PATIENT INFORMATION

NAME (LAST) (FIRST) (INITIAL) | SEX ☐ MALE ☐ FEMALE | AGE | DATE OF BIRTH | SOCIAL SECURITY NO.

ADDRESS (NO) (STREET OR RR#) (CITY) (STATE) (ZIP) | HOME PHONE NO. | MARITAL STATUS ☐ SIN ☐ MAR ☐ WID ☐ DIV ☐ SEP

PATIENT OR PARENT'S EMPLOYER | OCCUPATION | EMPLOYERS ADDRESS | BUSINESS PHONE NO.

SPOUSE NAME | SPOUSE'S EMPLOYER | OCCUPATION | BUSINESS PHONE NO.

RESPONSIBLE PARTY (if different from patient): (LAST) (FIRST) (INITIAL) | PATIENT RELATIONSHIP TO INSURED ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

RESPONSIBLE PARTY (Address) (NO) (STREET OR RR#) (CITY) (STATE) (ZIP)

NAME OF NEAREST RELATIVE (not living at same address) | RELATIONSHIP TO PATIENT | PHONE

PATIENT'S 2ND ADDRESS (NO) (STREET OR RR#) (CITY) (STATE)

GUARANTOR INFORMATION

The guarantor is the holder of the health insurance policy; or if there is no health insurance, the person responsible for the bill.

PRIMARY INSURANCE COVERAGE

SUBSCRIBER ______ DATE OF BIRTH ______ SS # ______

POLICY ID ______ EFFECTIVE DATE ___/___/___ Thru ___/___/___

INSURANCE CO. NAME & ADDRESS

EMPLOYER RELATIONSHIP TO PATIENT

SECONDARY INSURANCE COVERAGE

SUBSCRIBER ______ DATE OF BIRTH ______ SS # ______

POLICY ID ______ EFFECTIVE DATE ___/___/___ Thru ___/___/___

INSURANCE CO. NAME & ADDRESS

EMPLOYER RELATIONSHIP TO PATIENT

ADDITIONAL INSURANCE COVERAGE

SUBSCRIBER ______ DATE OF BIRTH ______ SS # ______

POLICY ID ______ EFFECTIVE DATE ___/___/___ Thru ___/___/___

INSURANCE CO. NAME & ADDRESS

EMPLOYER RELATIONSHIP TO PATIENT

PERSON TO CALL IN CASE OF EMERGENCY

Name: ______ Phone #: ______

Relationship: ______

Referred by: ______

Release of Benefits and Information: I authorize my insurance benefits to be paid directly to the doctor, I am financially responsible for any balance due. I authorize the doctor or insurance company to release any information required for this claim. A copy of this is as valid as the original.

Signed: ______ Date: ______