Welcome To Our Office

Dr. Brian D. Rotskoff

Patient Name**:_____

Date of Birth**:_____ Age:_____ Sex F M S.S.#**:_____

Address**:_____

City**:_____ State**:_____ Zip Code**:_____

Telephone # (Home)**:_____ (Home Fax)**:_____

(Work)**:_____ (Cell)**:_____

Email Address**:_____ Can we send you email? ___Y ___N

Marital Status: ___Married ___Separated ___Divorced ___Widowed ___Single ___Partnered

Employer**:_____

Employer's Address**:_____

How did you hear about us? ___Internet ___Friend ___Family ___Newspaper ___Other

Name of person who referred you_____ Their Phone #_____

Was there a doctor who referred you**? ___Y ___N Name**:_____

In Case of Emergency, Please Notify:

Name:_____ Relationship:_____

Address:_____

City:_____ State:_____ Zip Code:_____

Telephone # (Home):_____ (Work):_____ (Cell):_____

	Primary Insurance	Secondary Insurance
Name of Policy Holder**		
Address**		
City, State, Zip**		
Relation to patient**		
Social Security #**		
Date of Birth**		
Insurance Co.**		
Policy/ID #**		
Group #**		
Employer Name**		

I the undersigned hereby authorize the staff to perform such services as deemed necessary by the physician to diagnose and treat my conditions. Further, I authorize assignment of my insurance rights and benefits directly to this provider and also authorize the release of such information as is needed to process insurance claims. I understand that I am responsible for all charges which may include legal fees, collection fees or other expenses incurred by the provider in collecting my account. I hereby order all parties to accept a copy of this release and assignment in lieu of the original. This shall remain in effect until revoked by me in writing.

_____ _____

Authorized Signature of Subscriber Date