

The Practice of  
**CHARLES O. BRANTIGAN, MD**  
PATIENT INFORMATION FORM

**PATIENT** (Please print legibly and please complete all items)

Name \_\_\_\_\_ Spouse's Name \_\_\_\_\_  
Last First Initial

Address \_\_\_\_\_  
Patient's Street Address Apt. # City State Zip Code

Email Address \_\_\_\_\_

Sex M F Marital Status M S D W SS # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Home # ( ) \_\_\_\_\_ Work # ( ) \_\_\_\_\_ Cell # ( ) \_\_\_\_\_

**Referring Physician** \_\_\_\_\_ Phone ( ) \_\_\_\_\_

**Primary Physician** (if different than above) \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_

**Work Related?** \_\_\_\_\_ **Auto Accident Related?** \_\_\_\_\_ **Date of Injury** \_\_\_\_/\_\_\_\_/\_\_\_\_\*

**PRIMARY INSURANCE** (If you are a new patient and do not have your card, you will be entered as self-pay)

Insurance Company \_\_\_\_\_ Phone # \_\_\_\_\_

Claims Address \_\_\_\_\_ **Subscriber #** \_\_\_\_\_  
Address/P.O. Box City State Zip Code

**Group #** \_\_\_\_\_ **Subscriber Name** \_\_\_\_\_ **Subscriber Birthdate** \_\_\_\_\_ **OR**

**\*Claim #** \_\_\_\_\_ **Adjuster Name** \_\_\_\_\_ **Adjuster Phone** \_\_\_\_\_

**SECONDARY INSURANCE**

Insurance Company \_\_\_\_\_ Phone # \_\_\_\_\_

Claims Address \_\_\_\_\_ **Subscriber #** \_\_\_\_\_  
Address/P.O. Box City State Zip Code

**Group #** \_\_\_\_\_ **Subscriber Name** \_\_\_\_\_ **Subscriber Birthdate** \_\_\_\_\_

Emergency Contact (Not living with you) \_\_\_\_\_  
Name Home Phone Work Phone

I authorize payment to be made to the Charles O. Brantigan, MD. I authorize any holder of medical information about me to release to my insurance carrier and/or Health Care Financing Administration and its agents and/or my Medigap insurer any information needed to determine these benefits or the benefits payable for related services. As a courtesy to me, Charles O. Brantigan, MD will file all insurance claims, but I understand that, with the exception of Workers Compensation and some governmental insurance plans (e.g. Medicare and Medicaid), **I am responsible for the full amount of the charges. If I have no insurance, I will pay all charges at time of service unless other arrangements have been made.** I also authorize the release of any medical or other information to my referring physician. **I voluntarily consent to examination and treatment.**

**Date** \_\_\_\_\_ **Patient/Guarantor**

**Signature** \_\_\_\_\_