Ph: (573) 686-7575 ⚜ 2530 Lucy Lee Parkway, Poplar Bluff , MO 63901 ⚜ Fx: (573) 686-5199

DATE: ___________________

## ***PATIENT DATA- PLEASE PRINT***

PATIENTS NAME:_______________________________ SS# ____________________ BIRTHDATE: ______________

ADDRESS: _______________________________CITY:_________________________ST:________ZIP:______________

HOME # ________________AGE:_______ MALE:_____ FEMALE:_____ MARITAL STATUS: M___S___W___D___

EMPLOYER: _________________________________________________ WORK PHONE # _____________________

Cell Phone # __________________ E-mail Address ____________________________________________________

SPOUSE OR PARENTS NAME: __________________________________ ADDRESS __________________________

SPOUSE OR PARENTS EMPLOYER: _____________________________________ PHONE _____________________

EMERGENCY CONTACT: _____________________________________ RELATIONSHIP ____________________

EMERGENCY PHONE # ______________________________ YOUR PHARMACY __________________________

**WERE YOU REFERRED BY A CERTAIN DOCTOR?** YES _______ NO _______

IF SO, DR. &/OR CLINIC NAME _________________________________ PHONE NUMBER ___________________

IS YOUR VISIT DUE TO AN ACCIDENT? YES ____________ NO _____________

**REASON FOR VISIT:**________________________________________________________________________________

**ALLERGIES:** ______________________________________________________________________________________

## ***INSURANCE INFORMATION***
## ***(PLEASE SHOW ALL INSURANCE CARDS)***

**MEDICARE** _______________________________
MEDICAID _______________________________
BLUE CROSS BLUE SHIELD ________________ INSURED'S NAME: ________________________

OTHER: (commercial or supplement)
NAME OF COMPANY: _______________________________________________
INSURED PERSON: __________________________________________________

## ***MEDICAL RELEASE INFORMATION***

I HEREBY AUTHORIZE, **Milton R. Eichmann, M.D**., TO RELEASE ANY INFORMATION REQUESTED BY MY INSURANCE COMPANY IN REGARD TO PAYMENT OF MY CLAIM. I HEREBY ASSIGN ANY BENEFITS PAYABLE FOR MEDICAL SERVICES RENDERED TO THE ABOVE NAMED PHYSICIAN. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY CHARGES NOT PAID BY MY INSURANCE COMPANY.

SIGNATURE: _________________________________________________ DATE: _______________________________