MILES H. MASON, III, M.D.
ROBERT C. FRITZ, M.D.
MASON PRIMARY CARE

PLEASE PRINT

Patient's Full Name: ______________________________

Mailing Address: ______________________________

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City: ____________ State: ________ Zip: ________

Home Phone: ______ - ______ - ________ email address: ______________________

Date of Birth: _____ / _____ / _______ Age: ________ Sex: Male Female

Social Security #: ______________________

Guarantor Name: ______________________________

Address: ______________________________

______________ City: ____________ State: ______ Zip: ________

Employer: ______________________ Employer's Phone #: ______ - ______ - ________

Spouse Name: ______________ Employer: ______________ Phone #: ______________

Emergency Contact: ______________________ Phone #: ______________

INSURANCE INFORMATION

Primary Insurance Co: ______________________________

Insured Name: ______________________________

Insured ID #: ______________________ Insured Group # ______________________

Insured SS #: ______________________ Insured Birthdate: ______________________

Do you have a Co-pay? Yes No If Yes, what is it? ______________

Secondary Insurance Co: ______________________________

Insured Name: ______________________________

Insured ID #: ______________________ Insured Group # ______________________

Insured SS #: ______________________ Insured Birthdate: ______________________

Do you have any drug/environmental allergies? ______________________________

Who referred you to this practice? ______________________________

Any known chronic illnesses? ______________________________

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I hereby authorize the release of any medical information which may be required to process claims for payment of medical services to my insurance carrier, prepaid medical plan or Government Agency. When appropriate I authorize Assignment of surgical and/or medical benefits to Mason Primary Care.

X ______________________________ Date: ______________

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