Last Name____ First Name________________________________ MI___________

Address____

City____ State_________________ Zip___________________

Social Security #____ Date of Birth______________________________________

Sex: Male Female Marital Status: S M W D Other Email: ____

Telephone: Home__________________________ Work______________________________Cell________________________

PRIMARY INSURANCE is _________________________________ Are you the Primary Policy Holder (PPH) Yes No

Name as appears on card____

Identification #____ Group #____

If you are **not** the Primary Policy Holder (PPH) then you **must** provide the following information on the PPH of your plan:

PPH Name____ PPH Date of Birth__________________________

PPH Sex: Male Female PPH Social Security #____

What is your relationship to the PPH (circle one): Spouse Child Significant Other Other________________

SECONDARY INSURANCE is _____________________________ Are you the Primary Policy Holder (PPH) Yes No

Name as appears on card____

Identification #____ Group #____

If you are **not** the Primary Policy Holder (PPH) then you **must** provide the following information on the PPH of your plan:

PPH Name____ PPH Date of Birth__________________________

PPH Sex: Male Female PPH Social Security #____

What is your relationship to the PPH (circle one): Spouse Child Significant Other Other_________Employer

Name & Address____

Who is the responsible party for payment____

Address information if different from that provided above____

____

I have provided all of the requested information on this form. I understand that this information is required to file a claim to my primary and/or secondary insurance carrier(s) on my behalf. I hereby assign all medical benefits be paid directly to Gene E. Wyll, M.D., P.A. I will be fully responsible for payment of any and all unpaid medical services as determined by my insurance carrier(s). I also understand that I will be fully responsible for medical services that are not paid in a timely manner by my insurance carrier as applicable by state and/or federal law.

____ ____

Signature Date