BENJAMIN LEE, M.D.
PATIENT INSURANCE FORM

Patient Name: ___________________________________ Age: ______ Date of Birth: ___________
Address:____ City/State/zip: _____________________
Home Phone: ____________________________________Social Security #:___________________
Marital Status: Single _____ Married: _____ Other: ________ Gender: Male ______ Female: ______
Employer: ____________________________________ Work Phone #: ___________________
Spouse/Parent Name (if under 18): ____
Address (if different from above): ____
Referring Physician: ________________________________ Primary Care Physician: ____________

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INSURANCE INFORMATION

Primary Insurance
(Please check one) Policy holder: _________________________Self, Spouse, Parent, Other
___Health Insurance Company Name: ____
___Auto Accident Address: ____
___Workman's Comp Adjustor: ____________________________Phone #: _______________
___Other ID#: ___________________________________Group #: _______________
Policy #: _____________________________Claim #: ________________

Secondary Insurance
(Please check one) Policy holder: _____________________________________Self, Spouse, Parent, Other
___Health Insurance Company Name: ____
___Auto Accident Address: ____
___Workman's Comp Adjustor: _______________________Phone #: ________________
___Other ID#: _________________________________Group #: ________________
Policy #: _____________________________Claim #: _________________
Date of Injury: ________ Insured Name and DOB (if other than patient) _______________________
Do you have an attorney? __ Attorney Name: ____
Phone #: ____

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INSURANCE AUTHORIZATION AND ASSIGNMENT OF BENEFITS
PLEASE READ CAREFULLY AND SIGN BELOW

I hereby authorize Benjamin Lee, M.D. to furnish information to my insurance carriers concerning my illness/injury and treatment. I hereby assign Benjamin Lee, M.D. any and all payments for medical services rendered to myself and/or dependents. I understand that I am responsible for any amount not covered by my insurance. I also understand that if my account is turned over to a collection agency and/or legal counsel, I will be responsible for any collection and/or legal fees incurred in addition to the office charges.

SIGNATURE: ____ DATE: ____________

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WORKMAN'S COMP AUTHORIZATION

I authorize the release of medical information regarding my work injury sustained on _____________ to my employer ____

SIGNATURE: ____ DATE: ___________