NAME	MARITAL STATUS S / M / W / DIV / SEP	D.O.B.	S.S.
ADDRESS CITY ZIP CODE			
WHERE DO YOU PREFER TO RECEIVE CALLS: HOME WORK CELL ☐OK TO LEAVE MESSAGE		CELL PHONE	HOME PHONE
EMPLOYER	OCCUPATION	LEN. OF EMPL.	WORK PHONE
ADDRESS			DRIVER'S LIC. #
IN CASE OF EMERGENCY NOTIFY			PHONE
SPOUSES NAME		D.O.B.	SS#
SPOUSES EMPLOYER	OCCUPATION	LEN. OF EMPL.	WORK PHONE
ADDRESS			
INSURANCE CO. (PRIMARY)	GROUP # OR PLAN #	ID # IF DIFFERENT THAN PLAN OR GROUP #	
ADDRESS			
INSURANCE CO. (SECONDARY)	GROUP # OR PLAN #	ID # IF DIFFERENT THAN PLAN OR GROUP #	
ADDRESS			
IF MINOR OR STUDENT - RESPONSIBLE PARTY	ADDRESS		PHONE
WHO REFERRED YOU TO THIS PRACTICE?	PHONE	PHARMACY PHONE NUMBER:	

CO-PAYS AND DEDUCTIBLES MUST BE PAID AT THE TIME SERVICES ARE RENDERED.

AUTHORIZATION: I hereby authorize PATRICIA KORBER, M.D. to furnish information to insurance carriers concerning this or any illness, and hereby irrevocably assign to the doctor all payments for medical services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance. I further understand that a 1 3/4% finance charge (21% annually) will be added to any balance over 60 days. In event of death, I (we) promise to pay legal interest on the indebtness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

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RESPONSIBILITY PARTY SIGNATURE DATE