

TIMOTHY A. MURPHY, M.D.
PATIENT FORMATION

Date: _____

Cell: _____
(area code)

Home: _____
(area code)

Work: _____
(area code)

Preferred Contact #: Cell Home Work

Name: _____ Date of Birth: _____ Age: _____
(Last) (First) (Initial)

Address: _____

City: _____ State: _____ Zip: _____

Sex: M:___ F:___ Single:___ Married:___ Widowed:___ Separated:___ Divorced:___ Spouse: _____

Patient's Social Security #: _____ Patient's Employer: _____

Primary Care Physician: _____ Patient Referred By: _____

In case of emergency, who should be notified? _____ Phone: _____

PRIMARY INSURANCE

Primary Insurance Company: _____ Phone: _____

Primary Insured Person's Name: _____ Date of Birth: _____

Social Security #: _____ I.D.#: _____ Group #: _____

Insured Person's Address (if different from patient): _____

Insured Person's Phone: _____ Relationship to Patient: _____

Insured Person's Employer: _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? Yes: _____ No: _____ If yes, please turn over and complete the back of this form.

ASSIGNMENT, RELEASE, AND CONSENT TO TREAT

I AUTHORIZE Dr. Murphy to assess my condition and prescribe a treatment program. I also authorize the release of information to my primary care physician, the referring professional, and to any insurer for the purpose of remuneration to Dr. Murphy. I hereby assign directly to Dr. Murphy the payment of all insurance benefits.

I understand that I am financially responsible for all charges, whether or not paid by insurance.

Signature

Relationship

Date