JEFFREY L. MARKS, M.D., P.A., F.A.C.S.

NAME: Last ______________________________ MI _____ First ____________________ SEX : ____

AGE _____ BIRTH DATE ____/____/____ SOCIAL SEC # ______________ MARITAL STATUS: _____

ADDRESS __________________________________ Apt ____ City ______________ St _____ Zip ______

TELEPHONE: Home ________________ Work ___________________ Cell _____________________

OCCUPATION _________________________ EMPLOYER __________________________________

WORK ADDRESS__________________________________ City ______________ St ____ Zip _______

NAME OF SPOUSE: Last _________________________ MI ____ First _______________________

OCCUPATION ___________________________ EMPLOYER _____________________________

SOCIAL SEC # ________________ D.O.B. _____/_____/_____ CELL ____________________

EMERGENCY CONTACT _____________________________ _______________ _______________

Name Relationship Phone

REFERRED BY _____________________ FAMILY DR. _______________ PHONE _______________

PHARMACY ___________________________________ PHONE ____________________

If patient is under 18 years of age, please complete the following:

FATHER'S NAME ________________________ MOTHER'S NAME ________________________

Address (if different) _______________________ Address (if different) ________________________

D.O.B. __________ Home Tel. _______________ D.O.B. __________ Home Tel. ________________

SS # ______________ Cell ________________ SS # ______________ Cell ________________

INSURANCE INFORMATION

PRIMARY COMPANY ____________________ POLICY # _______________ GROUP #_____________

BILLING ADDRESS ____________________________ CITY ______________ STATE ____ ZIP _______

POLICYHOLDER __________________ RELATIONSHIP ___________________ D.O.B. ____________

SECONDARY COMPANY _____________________ POLICY # _______________ GROUP #__________

POLICYHOLDER __________________ RELATIONSHIP ___________________ D.O.B. ____________

PAYMENT POLICY

Copayments are due at the time of service. If copayment is not paid a $10.00 (ten dollar) fee will be added and billed.

As a courtesy to our patients, we will file your claim with your insurance company. You are responsible for any deductible or co-payment at the time services are rendered. It is the patient's responsibility to notify our office of any insurance changes and obtain referrals when required by your carrier. Any bill over 90 days is subject to an 18% interest charge. All unpaid balances that are outstanding after 90 days and have been billed to the patient will be sent to collections.

Medicare patients are advised that Medicare will pay 80% of their allowable fees after the deductible has ben met. The patient, by law, is responsible for the remaining 20%. However, we will gladly file your secondary insurance claim.

I authorize my insurer to make payments directly to Dr. Marks. A copy of this authorization may be used in place of the original and shall apply to all charges submitted by Dr. Marks. I authorize Dr. Marks to release any information regarding my examination or treatment to my insurer.

By signing this, I agree to the above terms and acknowledge that I have read this policy and understand the terms of this agreement. I understand and agree that I am personally responsible for payment of all professional services.

______________________________ ________________________________ __________________

Printed name of patient or Guardian, Signature Date

If patient a minor