BULL RUN FAMILY PRACTICE, P.C.

PRIMARY INSURANCE UPDATE

Date: ____________

Patient name: ____

Patient DOB: ______________

Patient Social Security #: ______________________

Insured's name: _______________________ Insured's SS #: _____________

Insured's Employer : ____

Work phone #: ________________________

Patient's Relationship to insured: SELF SPOUSE CHILD OTHER__________
(circle one)

NEW INSURANCE INFORMATION—COPY OF INSURANCE CARD NEEDED

Name of insurance: _______________________________________

ID#: ______________________________ Copay amt: $_____________

Group #: ___________________ Address for claims: ______________________

Effective date of new coverage: _______ ______________________________

ASSIGNMENT OF BENEFITS AUTHORIZATION

I request that payment be made on my behalf to Bull Run Family Practice, P.C. for any covered services furnished me. I also authorize release of medical information relevant to these services when required by the Health Care Financing Administration (HCFA), its Agents or insurance carriers, including any Medigap insurer indicated above, for determining eligibility of benefits.

MEDICAL INFORMATION MAY BE RELEASED TO: ***self only spouse parents Children message on answering machine other__________________***
(circle one or more)

SIGNATURE: ____

7/31/00(3)