Maria M. Doucet, M.D.

☐New Patient ☐New Insurance ☐Hospital Follow-up ☐Update

Date _______________ **PATIENT INFORMATION** MR#:_______________ (Office use only)

Cell Phone # (_____) ____________________ Home Phone # (_____) ________________ Email ___________________________

Name ____ **Soc. Sec. #** ____
Last Name **First Name** **Middle Initial**

Address (Mailing & Physical) ____

City ____State _____________ Zip Code ____________________

Sex ☐Male ☐Female Age _____ Date of Birth_________________ ☐ Minor ☐Single ☐Married ☐Divorced ☐Widowed

Patient Employed by ____ Occupation ____

Business Phone: __________________________ Name of Requesting Physician?______________________________________

Emergency Name & Relationship to patient: _ _______________________________________ Phone:____________________

If minor, Mothers name, Home phone, Work# & cell# ____

If minor, Fathers name, Home phone, Work# & cell# ____

If married, Spouse name, Work# & cell# ____

Who is financially responsible (Guarantor) for this patient: ☐Self ☐ ____

Address (**if different from patients**) ____________________________________ Phone ______________________________

City ____State ______________ Zip Code ___________________________________

PRIMARY INSURANCE Please indicate which type of policy: __ Medicare Primary __Individual __Group __ Medicaid __Other

Subscriber to Insurance ____
Last Name **First Name** **Middle Initial**

Relation to Patient_________________________ Date of Birth _______________ Soc. Sec. # ______________________________

Address (**if different from patients**) ____________________________________ Phone ______________________________

City ____State ______________ Zip Code ___________________________________

Subscriber Employed by ____________________________________ Occupation ______________________________________

Business Phone _____________________________

Insurance Company Name ____

Member/Subscriber/Contract # ____ Group # ___________________________

Is patient covered by additional insurance? ☐Yes ☐No **ADDITIONAL INSURANCE** Please indicate which type of policy below:

__Individual __Group __Medicare Supplement __ Medicaid __ Medicare __Other

Subscriber to Insurance ____
Last Name **First Name** **Middle Initial**

Relation to Patient_________________________ Date of Birth _______________ Soc. Sec. # ______________________________

Subscriber Employed by: ____Business Phone ____________________________

Insurance Company ____

Member/Subscriber/Contract # ____ Group # ___________________________

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Maria M. Doucet, M.D.

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with ____

____ and assign directly to **Maria M. Doucet, M.D., A.P.M.C.** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by Insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. If this account should become deficient or delinquent and is turned over to a collection agency, I will be responsible for all fees pertaining to collections, legal fees and/or court cost.

I hereby request and authorize **Maria M. Doucet, M.D., A.P.M.C.** to disclose any medical information relating to diagnosis, care, treatment and prognosis concerning myself to the individual(s) listed below. I understand that information may be obtained either in person, in writing, or by telephone. I understand that I am allowing the above office to leave messages about my scheduled appointments on an answering machine.

(Patient - please list anyone (family or friends) whom you would allow to have access to your medical record, both written and verbal.

Authorization for Patient (Minor) to be Treated

I, ____, authorize the individual(s) that are listed below to bring my child
(Name of parent/legal guardian - Please print)

____, into the office of Dr. Maria M. Doucet and to be treated by Dr. Maria M. Doucet. I realize that I am giving these individuals the authorization to make medical decisions, excluding authorization for surgery, on my behalf. This authorization is good for a period of 1 (one) year from the date on this form or until a written revocation is issued to our office by a parent or a legal guardian.

Name: ______________________________________ Relationship: ____________________________________

Name: ______________________________________ Relationship: ____________________________________

Name: ______________________________________ Relationship: ____________________________________

Name: ______________________________________ Relationship: ____________________________________

Signature: ____ Date: ____