**Nick H. Gabriel, DO, FACOS**

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# INFORMATION FORM

Date _____

## PATIENT INFORMATION

Name _____
Address _____
_____

Home Phone _____
Cell Phone _____
Work Phone _____
E-mail _____
Date of Birth _____
Age _____ Gender _____
SS# _____
Marital Status _____
Employer _____
Employer Address _____
_____
Employer Phone _____
Occupation _____

REFERRED BY _____

PRIMARY CARE PHYSICIAN
Name _____
Address_____
_____
Phone _____

## INSURANCE INFORMATION

**Primary Insurance**
Plan Name _____
Identification #_____
Group # _____
Policy Holder: ( ) Self ( ) Spouse ( ) Parent
Name _____
Date of Birth _____
SS# _____

**Secondary/Supplemental Insurance**
Plan Name _____
Identification #_____
Group # _____
Policy Holder: ( ) Self ( ) Spouse ( ) Parent
Name _____

**Guarantor Information (*if not patient*)**
Name _____
Address _____
_____
Home Phone _____
Cell Phone _____
Work Phone _____
E-mail _____
Date of Birth _____
SS# _____

**Emergency Contact Information**
Name/Relation _____
Phone # _____

### ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical benefits to which I am entitled, including major medical, Medicare, private insurance and any other health plans to Nick H. Gabriel, DO. This agreement will remain in effect until revoked in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

Patient Signature _____ Date _____

### CONSENT TO RELEASE MEDICAL INFORMATION

I hereby give permission for the release of medical information about myself to the office(s) of Nick H. Gabriel, DO to use at their discretion when deemed necessary in my interest.

Patient Signature _____ Date _____