Please use ink!

KEITH E BERGER, M.D.

CENTER FOR HEALTH & CANCER PREVENTION

Patient Name: Last_____ First_____ M.I. ___

Address(#,Street, Box)_____

(City,State,Zip)_____ Phone #_____

Email Address:_____Cell Phone #_____

Sex___ Male ___Female Marital Status ___Single ___Married ___Widow

Birthdate_____ SS#_____

Referring Doctor_____Family Doctor_____

Employer_____ Work Phone #_____

Employer Address (City, State, Zip)_____

Spouse_____Birthdate_____SS#_____

Spouse Employer_____ Phone #_____

Emergency Contact Person_____Phone#_____

We will file your insurance; however, **you are responsible for deductibles, co-payments and non-covered services.**

*********** Please contact your insurance company to verify coverage information.***********

1) Primary Insurance_____ Policy#_____

Subscriber Name_____Group# or Name_____

Relationship to Subscriber ____Self ____Spouse ____Child _____Other

2)Secondary Insurance_____Policy#_____

Subscriber Name_____Group# or Name_____

Relationship to Subscriber ____Self _____Spouse ____Child _____Other

I request payment of authorized health insurance benefits be made to me or on my behalf to Dr Berger of CENTER FOR HEALTH & CANCER PREVENTION for services rendered to me. In the event of default, I agree to pay the balance and all costs of collection, including attorney's fees in the amount of 33.5% of the total amount due when turned over to collections. Insurance authorization and assignment of benefits is effective until revoked. If health care workers expose themselves to my body fluids, I agree to have my blood tested for any infectious disease, which might be transmitted.

Patient or Guardian Signature_____ Date_____