

Quad City Rheumatology, S.C.
Michael F. Miniter, M.D.
4362 7th Street
Moline, IL 61265

SS# _____ FIRST NAME _____ LAST NAME _____ MI _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME # _____ WORK# _____ CELL# _____

REFERRING DOCTOR _____ FAMILY DOCTOR _____

SEX _____ BIRTH DATE _____ CHECK ONE () MARRIED () SINGLE () WIDOW () OTHER _____

SPOUSE'S NAME _____

IS PATIENT (PLEASE CHECK ONE) () EMPLOYED () RETIRED () STUDENT () OTHER _____

EMPLOYER NAME & ADDRESS _____

EMERGENCY #, NAME & RELATIONSHIP _____

INSURANCE INFORMATION
(PLEASE PROVIDE FRONT DESK WITH A COPY OF INSURANCE CARD)

PRIMARY INSURANCE SUBSCRIBER (PERSON CARRING INSURANCE) _____

SUBSCRIBER (PLEASE CHECK ONE) () SELF () SPOUSE () PARENT () OTHER _____

BIRTH DATE OF ABOVE SUBSCRIBER _____ AND SS# _____

EMPLOYER OF ABOVE _____ OR () RETIRED () OTHER _____

SECONDARY INSURANCE SUBSCRIBER (PERSON CARRING INSURANCE) _____

SUBSCRIBER (PLEASE CHECK ONE) () SELF () SPOUSE () PARENT () OTHER _____

BIRTH DATE OF ABOVE SUBSCRIBER _____ AND SS# _____

EMPLOYER OF ABOVE _____ OR () RETIRED () OTHER _____

PLEASE NOTIFY FRONT DESK IS THIS IS A WORKERS' COMPENSATION CLAIM—PRIOR AUTHORIZATION IS REQUIRED BEFORE RECEIVING MEDICAL CARE

PLEASE TURN OVER TO SIGN & COMPLETE

Quad City Rheumatology, S.C.
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ASSIGNMENT OF BENEFITS

Your signature is required so that we may process any insurance claims and enable us to receive payment for services rendered.

I hereby authorize the release of any medical information pertinent to my medical care that is necessary to process my insurance claims and to assign benefits directly to the above named physician and or clinic. This assignment of benefits is in effect until otherwise revoked by me in writing. A photocopy of this "assignment of benefits" may be used and is considered as valid as the original.

I HAVE READ THIS FORM AND UNDERSTAND IT'S CONTENTS AND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED.

X _____ X _____
SIGNATURE DATE WITNESS

PLEASE COMPLETE ONLY IF PATIENT IS A MINOR CHILD

FATHERS NAME _____	MOTHERS NAME _____
BIRTH DATE _____ SS# _____	BIRTH DATE _____ SS# _____
ADDRESS _____	ADDRESS _____
HOME# _____ WORK# _____	HOME# _____ WORK# _____
EMPLOYER _____	EMPLOYER _____