

TROY FAMILY PRACTICE, P.L.L.C.

SHAWN P. SYRON, M.D. STACEY BELTZ, D.O. HARJANEET BEDI, M.D. ANN FORDE, N.P.

Last Name: _____ First Name: _____ Sex: M / F

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Alternate Phone: _____

Social Security #: _____ Birth Date: _____

Employer: _____

Legal Guardian/ Parent (if patient is a minor) or Spouse: _____

Medication Allergies: _____

In case of emergency contact: _____

Relationship: _____ Phone #: _____

Do you have an Advanced Directive or Living Will? Yes / No

IF YOU WOULD LIKE THIS OFFICE TO RELEASE/DISCUSS YOUR MEDICAL INFORMATION WITH SOMEONE OTHER THAN YOURSELF, PLEASE COMPLETE THE FOLLOWING:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature: _____ Date: _____

I AUTHORIZE THE DOCTOR TO BILL MY INSURANCE CARRIER AND IF NECESSARY TO RELEASE ANY MEDICAL OR PERSONAL INFORMATION REQUIRED TO PROCESS THE INSURANCE CLAIM ON MY BEHALF.

Signature: _____ Date: _____

Primary Insurance: _____ Policy Holder _____ Birth Date _____