TROY FAMILY PRACTICE, P.L.L.C.
SHAWN P. SYRON, M.D. STACEY BELTZ, D.O. HARJANEET BEDI, M.D. ANN FORDE, N.P.

Legal Name:_____,_____ ___, _____ Sex: M / F
Last First Middle Initial/Name

Address:_____

City:_____ State:_____ Zip: _____

Daytime Phone #:_____ Alternate Phone #:_____

Social Security #:XXX-XX-_____ Birth Date:_____/_____/_____
Last 4 digits

Are you: Married Single Divorced Widowed

Medication Allergies:_____

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

Employer:_____

In case of emergency contact:_____

Relationship:_____ Phone #:_____

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

How did you hear about our office: Family member Friend Co-worker Newspaper add Web Site
Other_____

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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_____
Subscriber subscriber