Ronald L. Renard, MD., Inc.

Patient Name: _____
Last First Middle

Date of Birth: ___/ ___/_____ Male / Female Ethnicity _____ Marital status: S M W D

Driver's License #: _____Social Security #: _____

Home Phone: _____Cell Phone _____

Address: _____City _____Zip_____

Employer/School _____
Name Location Phone number

Primary Physician: _____ Referred by: _____

Emergency Contact: _____Phone _____

If patient is a minor, please list both parents. If you are an adult, and you are married, list your spouse. If you are a non-parent guardian, please provide proof of guardianship.

Name: _____ Date of Birth: ___ / ___ /_____ Relationship_____

Address: _____ City _____ Zip _____
(If different from patient)

Employer: _____
Name Location Phone number

Name: _____ Date of Birth: ___ / ___ /_____ Relationship_____

Address: _____ City _____ Zip _____
(If different from patient)

Employer: _____
Name Location Phone number

You must bring your insurance card along with your government issued photo ID; please give these to receptionist with this form.

Primary Insurance: _____ Subscribers Name: _____

Insured's relationship to patient: _____

Secondary Insurance: _____ Subscribers Name: _____

Insured's relationship to patient: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Dr. Renard or insurance company to release any information required to process my claim.

Name_____ Signature _____ Date _____