FRANCIS A. PFLUM, M.D.

Date:______________________________Referred By:____________________________

Name:____Sex M F

Address:____

City:______________________State:__________________Zip:___________________

Date Of Birth:_________________________Age:________

Home Phone:( )_______________________ Cell #:____________________________

Social Security Number:____

Employer:____

Address:____

Employer Telephone: ( )____

INSURANCE INFORMATION

Name of Insurance____

Address:____

ID #:______________________________Policy #:________________________________

PLEASE NOTE DR FRANCIS A. PFLUM IS NOT A PROVIDER OF ANY INSURANCES BUT IF YOU HAVE OUT OF NETWORK BENEFITS WE WILL DO OUR BEST TO ACCOMMODATE AND HELP YOU WITH RE-IMBURSEMENT.

I hereby authorize the release of all medial information necessary to process any and all medical surgical claims, and commission the payment of said claims directly to Dr. Francis A. Pflum for services rendered. I further acknowledge that I am ultimately responsible for the payment of all medical surgical claims submitted by Dr Francis A. Pflum on my behalf.

Signature ____Date:________________