## A. MICHAEL GLOVER, M.D., F.A.C.S.

How did you hear about us? _____

Date_____ Referred by Dr._____

Name_____
First Middle Maiden Last

Age_____ Date of Birth _____ Social Security #_____

Male_____ Female_____ Single_____ Married_____ Other_____

Street Address _____

City_____ State_____ Zip_____

Home Phone #_____ Work Phone #_____ Cell Phone #_____

Employer_____ Address _____Phone # _____

Spouse's Information (or parent, if child)

Name_____ SS#_____ Date of Birth_____

Employer_____ Phone #_____

In Case of Emergency Contact (someone not living with you) _____

Relationship _____ Phone_____

Primary Insurance_____ ID#_____

Group #_____ Policy holder (check one): Self_____ Spouse_____ Parent_____

Secondary Insurance_____ ID#_____

Group #_____ Policy holder (check one): Self_____ Spouse_____ Parent_____

I hereby authorize Dr. Michael Glover to furnish information to my insurance carriers concerning my illness and treatments, and hereby assign Dr. Glover all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not paid by insurance. I understand that if I have not secured appropriate authorizations and otherwise complied with the terms of my health benefit plan, there may be a decrease or no coverage at all for some or all of the services which I am about to receive, and will be financially responsible for the services not covered.

Date_____ Signed_____

I authorize and give my consent to disclose my personal health care information to those involved in my healthcare.

Date_____ Signed_____