Dr David R. Allen M.D.

LAST NAME:		**HOME #:**
FIRST NAME:	**M.I.:**	**WORK #:**
STREET:		**DATE OF BIRTH:**
APT/SUITE #:		**MEDICARE?** *Yes No* — **SEX:** *M - F*
CITY:	**STATE:**	**ZIP CODE:**
E-MAIL:		**Social Security #:**
Occupation:		**Driver's License:**
Employer/School:		**Expiration Date:**
Referred By:		**Marital Status:** *S - M - D - W*
Emergency Contact:		**Phone:**

Authorization To Release Information

I hereby authorize Dr. Allen - to release any medical information
that may be necessary for medical care or for processing insurance information.

Patient Financial Responsibility

All fees for professional services are due and payable at the time the services are rendered.
We gladly provide all necessary billing information to expedite insurance payment to the patient.
We also provide direct billing for Medicare claims on behalf of our patients.
However, we do NOT accept assignment of insurance benefits or Medicare.
The patient is responsible for all fees incurred, regardless of insurance coverage.

What are your current symptoms and complaints?

a:
b:
c:

Current medications:

a:	d:
b:	e:
c:	f:

List all medications to which you are allergic: ______________________

FOR OFFICE USE ONLY: *POST ALL INFO IN CAPS.* *F/O INITIALS*__________

Patient Signature: ________________________________ Date: ________________________________

FOR OFFICE USE ONLY: *POST ALL INFO IN CAPS.* *F/O INITIALS*__________