ACCOUNT NUMBER	EDWARD J. SHARE, M.D.	DATE:

PATIENT INFORMATION

PATIENT'S LAST NAME	FIRST NAME	MIDDLE NAME	SEX	BIRTHDAY
				//

PATIENT'S ADDRESS

CITY	STATE	ZIP CODE

HOME PHONE	MOBILE PHONE	PATIENT'S SOCIAL SECURITY NUMBER

MARITAL STATUS	AGE	DRIVER LICENSE NUMBER

E-MAIL ADDRESS	BUSINESS PHONE	OCCUPATION

PATIENT'S BUSINESS NAME / ADDRESS

SPOUSE	OCCUPATION

SPOUSE'S BUSINESS NAME / ADDRESS	BUSINESS PHONE

REFERRED BY	ADDRESS
INTERNIST / PRIMARY PHYSICIAN	ADDRESS

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY	SUBSCRIBER
ADDRESS	EMPLOYER

GROUP NUMBER	I.D. NUMBER	PLAN NUMBER

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY	SUBSCRIBER
ADDRESS	EMPLOYER

GROUP NUMBER	I.D. NUMBER	PLAN NUMBER

NAME OF FRIEND OR RELATIVE OR GUARDIAN OR PARENT NOT LIVING WITH PATIENT

NAME	RELATIONSHIP
ADDRESS	PHONE

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize Edward J. Share, M.D. to furnish information to insurance carriers concerning this illness, and I hereby irrevocably assign to the doctor all payments for medical services rendered. I understand that I am financially responsible for all charges not covered by my insurance benefits. I hereby grant permission to appeal Insurance Claims on my behalf. I hereby acknowledge that I have read and understood the "Notice of Privacy Practices".