

PLEASE CHECK ALL THAT APPLY:

- I am retired
- I am disabled
- I have more than one health insurance plan.
- I receive my health insurance through MY place of employment
- I receive my health insurance through my spouse.

(If yes, please answer the following: _____ Name of spouse
 _____ DOB
 _____ SS#
 _____ employer

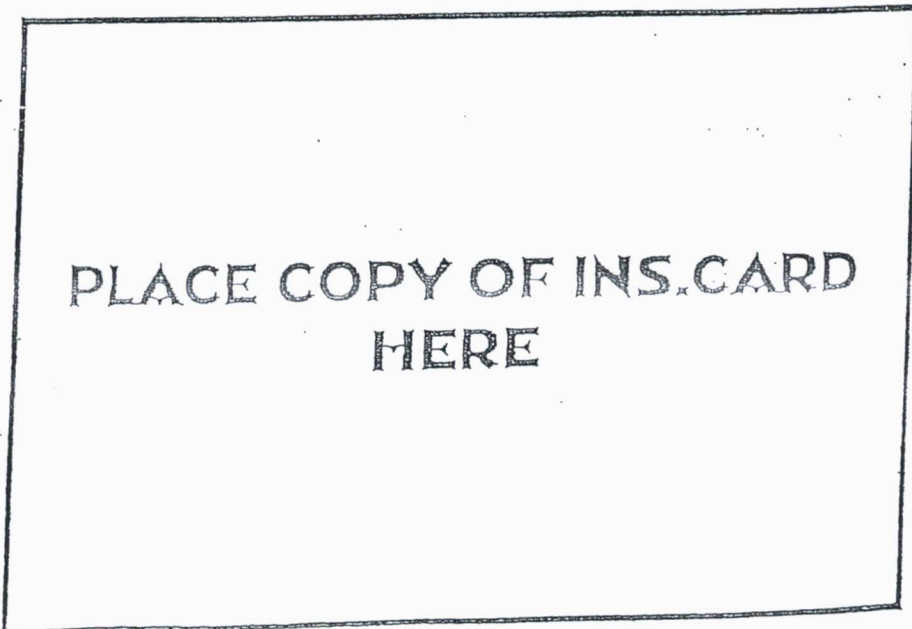
I authorize Drs.Kroopnick & Sherman,P.A. to apply for benefits on my behalf for services rendered. I request payment from _____ to be made
enter your ins.co.name here
 directly to Drs. Kroopnick & Sherman, P.A.

_____ Date: _____
 Signature of subscriber

I certify that all the information I have reported is correct ,and further I authorize the release of any necessary information including medical information for this or any related claim to _____. I permit a copy of this
enter your insurance co. name here

authorization to used in place of the original. The authorization may be revoked by me at any time in writing.

_____ Date: _____
 Patient's Signature



_____ Initials
 _____ Insurance verified