

REGISTRATION
(PLEASE PRINT)

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NEW PATIENT INFORMATION

NAME : _____ DATE OF BIRTH : _____
ADDRESS : _____ HOME PHONE : _____
(STREET) (CITY) (ZIP)
WORK PHONE : _____ MARITAL STATUS : _____ SPOUSE'S NAME : _____
SS # : _____ EMPLOYER : _____
SPOUSE'S EMPLOYER : _____ PHONE: _____
RELATIVE / FRIEND, OTHER THAN SPOUSE : _____
(NAME) (PHONE)

INSURANCE INFORMATION

PRIMARY CARRIER

MEDICARE # : _____ MEDICAID # : _____
NAME OF INSURANCE COMPANY : _____
NAME OF INSURED : _____ GROUP WITH : _____
GROUP # : _____ ID # : _____ CERTIFICATION # : _____
ANY OTHER #S REQUIRED FOR FILING : _____
ADDRESS FOR MAILING CLAIMS : _____
(STREET) (STATE) (ZIP)

SECONDARY / SUPPLEMENTAL CARRIER

MEDICARE # : _____ MEDICAID # : _____
NAME OF INSURANCE COMPANY : _____
NAME OF INSURED : _____ GROUP WITH : _____
GROUP # : _____ ID # : _____ CERTIFICATION # : _____
ANY OTHER #S REQUIRED FOR FILING : _____
ADDRESS FOR MAILING CLAIMS : _____
(STREET) (STATE) (ZIP)

ASSIGNMENT OF INSURANCE BENEFITS

I request that payment of authorized Medicare benefits be made to me, or on my behalf, to Jeffrey M. Shea, M.D., P.A. for any services furnished me by that provider. I authorize any holder of medical information about me, to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown.

Signature of Patient or Authorized Representative