

Antonio M. Bird, MD, PA
14 South Pack Square, Suite 362
Asheville, NC 28801

Today's Date _____

PATIENT INFORMATION

First Name _____ M.I. ____ Last Name _____ Mr./Ms./Mrs./Dr.

Prefer to be called _____ SSN _____ Date of birth _____

Address _____

Phone (home) _____ (work) _____ (cell) _____

****Please place an asterisk beside the preferred phone number for contacting you.****

If we need to contact you at home or work may we leave a message? _____ Yes _____ No

Special instructions _____

Referral Source _____ Place of employment _____

Is your condition work-related? _____ Yes _____ No

Name of primary care physician _____

Address/Tel. _____

Do we have your consent to release information to this physician? _____ Yes _____ No

Signature for Consent _____

Emergency Contact Name _____ Relationship _____

Address _____

Phone (home) _____ Phone (work) _____

Who is financially responsible for this bill? _____

****Person responsible for payment must sign the Practice Policies form. If paying by credit card, name on credit card must match signature on Practice Policies form.****

How will you be paying today? _____ Cash _____ Check _____ Visa/Master Card

Card type _____ Credit card number _____

Name on card _____ Expiration date _____

Billing address _____

Will you be filing insurance? _____ Yes _____ No If "yes," this is my authorization to release any information necessary to insurance companies in order to process payment on this account or to authorize payment for medications prescribed.

Signature _____

NOTE TO MEDICARE and TRICARE PATIENTS: This office does not participate in the Medicare or Tricare programs. If you would like to receive services, with the understanding that the cost of those services will not be covered, then a separate document must be executed before services can be provided.