



PATIENT INFORMATION

Phone (605) 886-8650

810 10th Street SW
Watertown, SD 57201

Name _____ Social Security Number _____

Address _____ Home Phone _____

City _____ State _____ Zip _____

Occupation _____

Employer _____ Work Phone _____

Age _____ Birthdate _____ Marital Status _____ No. of Children _____

Spouse's Name _____ Email Address _____

In Case of Emergency, Notify _____ Phone _____

Is This Condition: Job Related? Yes No _____ Auto Accident? Yes No

Who Referred You To Us? My doctor Yellow Pages
 Radio Someone else, please identify who: _____

Insurance Company _____ Policy Number: _____

Authorization: I hereby authorize Dr. Deutsch to furnish any and all information to insurance carriers concerning this illness/accident, and I hereby irrevocably assign to the doctor all payments for medical services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance. A copy of this authorization shall be considered as valid as the original.

I hereby instruct and direct the insurance provider to pay directly to Doctor Deutsch's office all benefits the policy allows for services rendered. If the current policy prohibits direct payment to the health care provider, than I also instruct and direct the insurance company to make the check payable to both myself and my health care provider. I also authorize my health care provider and its agents and employees to act on my behalf in all matters pertaining to my care and treatment. This is a direct assignment of my rights and benefits under any policy.

A photocopy of this agreement shall be considered as effective as the original.

Signature _____ Date _____