

**Dr. Robert G. Cooper MD, FACS - 505 S. Popular Street - Seymour, IN 47274**

**Patient Information**

Last Name	First Name	Middle Initial
Address-Street	City	State/Zip Code
Patient's Date of Birth	Social Security Number	Home Phone # / Mobile Phone # H _____ M _____
Student Status <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	Employment Status <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Unemployed <input type="checkbox"/> Other _____	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Name/Address of Employer	Occupation
Work Phone #	Primary Care Physician:	
Emergency Contact Name	Address	Phone #

**Guarantor's Billing Information**

Last Name	First Name	Middle Initial
Address – Street	City	State/Zip Code
Relationship to Patient	Social Security Number	Home Phone #
Employer	Employer's Address	Work Phone #

**Insurance Information**

PRIMARY INSURED INFORMATION			SECONDARY INSURED INFORMATION		
Last Name of policy holder	First Name/Middle I. of policy holder		Last Name of policy holder	First Name/Middle I. of policy holder	
Address	City/State/Zip		Address	City/State/Zip	
Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other			Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female			Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		
Insured's Date of Birth	Insured SSN		Insured Date of Birth	Insured SSN	
Name & Address of Insurance Co.			Name & Address of Insurance Co.		
ID #	Group #	Effective Date	ID#	Group #	Effective Date
Name of Employer Sponsoring Plan			Name of Employer Sponsoring Plan		

**Consent To Payment**

I have listed all health insurance plans from which I may receive benefits. I hereby authorize payment of medical benefits billed to my insurance to Dr. Robert G. Cooper. I hereby accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. I also accept responsibility for fees that exceed the payment made by my insurance, if Dr. Robert G. Cooper does not participate with my insurance. I agree to pay all co-payments, coinsurance, and deductibles at the time services are rendered.

\_\_\_\_\_  
Signature of Patient/Patient's Guardian

Printed Name of Patient \_\_\_\_\_

\_\_\_\_\_  
Date

Relationship of Representative to patient: \_\_\_\_\_