Patient Insurance Form
SCOTT M. TAYLOR, M.D.
A Professional Corporation
400-29th Street, Suite 400, Oakland CA 94609

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Please PRINT and complete all sections

Dr.
Mr.
Mrs.
Ms. Last Name_____________________________________ First Name_____________________ Middle Initial_______

Home Address:____

City: _____________________________________ State: _______ Zip Code: __________ Male Female

Hm. Ph#____________________ Cell Ph#__________________________ Work Ph#______________________________

Date of birth__________________ Driver's Lic. #: __________________ Fax #:_________________________________

E-Mail Address: ____ SS#: _____________________________

Employer:____ Occupation:____________________________

Employer Address:____

Spouse's Name:____ Hm. Ph#_____________________________

Spouse's Employer:____ Wk Ph#__________________________

Employer's Address:____

Circle One: Married Single Divorced Widow Separated Domestic Partner

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Name of Insurance: ____

Name of Insured (if different from above)____

ID#.Policy#/Claim#: (**Please give insurance cards to receptionist**)____

Primary Care Physician:____

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Contact in case of emergency:____

Phone Number:____ Relationship:_________________________________

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I, the above named patient hereby certify that all the above information is true and correct. I understand that if the above is not true or if I'M not eligible under the terms of my Medical Insurance Agreement, I am liable for all charges for services rendered. I authorize my Insurance Company to pay benefits directly to Dr. Scott M. Taylor and authorize Scott M. Taylor, M.D., to release any information required to process this claim.

I understand that all payments (medical services, co-pays, deductibles and deposits) are due at the time of service. Cash, checks and credit cards are acceptable methods of payment. **I also understand that I will be responsible to pay a $25.00 charge due to all missed appointments which are not canceled 24 hours in advance. THIS RULE IS STRICTLY ENFORCED!**

____ ______________________________
Patient's Signature Date