STARK MEDICAL SPECIALTIES, INC.

OFFICES: 323 MARION AVE. N.W., MASSILLON, OH 44646 (330) 837-1111 or (330) 832-7777
830 S. MAIN ST., ORRVILLE, OH 44667 (330) 682-0068
821 ANOLA AVE., SUITE B., DOVER, OH 44622 (330) 343-7581

APPOINTMENT DATE/TIME: ____
DOCTOR:______________________________

FIRST NAME_____________________________ MI_______ LAST__________________________
SS#____________________________

ADDRESS________________________________ CTY/STATE:___________________________ZIP___________PHONE (______)__________________

MARITAL STATUS: S M W D SEP DOB__________________ AGE_____________ SEX: M F

EMPLOYER____
OCCUPATION____

EMP. ADDRESS__________________________________ CITY/STATE_______________________________ ZIP________ PHONE (_____)_________

GUARANTOR (OR RESPONSIBLE PARTY IF DIFFERENT FROM PATIENT) (PERSON RESPONSIBLE FOR PAYMENT)

GUARANTOR NAME________________________________ MI____ LAST________________________________
SS#___________________________

EMPLOYER____
OCCUPATION____

EMP. ADDRESS__________________________________ CITY/STATE______________________________ ZIP________ PHONE (______)_________

INSURANCE INFORMATION:

PRIMARY INS____ GROUP #_______________________ POLICY #_____________________

POLICY HOLDER'S NAME ____
ADDRESS____

PHONE(_______)______________________ POLICY HOLDER DOB_____________________ POLICY EFFECTIVE DATE________________

SECONDARY INS____ GROUP#_____________________
POLICY#___________________

POLICY HOLDER'S NAME ____
ADDRESS____

PHONE(______)______________________ POLICY HOLDER DOB_____________________ POLICY EFFECTIVE DATE________________

MEDICAID____ CASE NAME________________________________ PROGRAM_______ RECPT#:______ CASE#________________ EFF DATE______

INDUSTRIAL___ INJURED ON THE JOB: YES NO DATE OF INJURY_________________ EMPLOYER___________________ CLM #_________

ACCIDENT___ AUTO INVOLVED: YES NO DATE OF ACCIDENT_______________
LOCATION____

ARE YOU WORKING NOW: YES NO EMPLOYER____ DATE OF LAST DAY WORKED___________

WHO REFERRED YOU___________________________________ ADDRESS____________________________________
PH#(______)_______________

NAME OF FAMILY DOCTOR_____________________________ ADDRESS___________________________________
PH#(______)_______________

LAST DOCTOR SEEN___________________________________ ADDRESS___________________________________
PH#(______)_______________

PATIENTS WHO CARRY HEALTH INSURANCE SHOULD REMEMBER THAT PROFESSIONAL SERVICES ARE RENDERED AND CHARGED TO THE PATIENT AND NOT THE INSURANCE COMPANY. EVEN THOUGH AN INSURANCE CLAIM IS FILED, YOU WILL RECEIVE A STATEMENT EACH MONTH IF YOUR ACCOUNT HAS A BALANCE DUE. THIS OFFICE CANNOT ACCEPT RESPONSIBILITY FOR COLLECTING YOUR INSURANCE CLAIM OR NEGOTIATING A SETTLEMENT ON A DISPUTED CLAIM. YOU ARE RESPONSIBLE FOR PAYMENT OF YOUR ACCOUNT WITHIN THE LIMITS OF OUR CREDIT POLICY.

I CERTIFY THAT THE INFORMATION ON THIS FORM PROVIDED BY ME IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

SIGNATURE OF PATIENT (OR PARENT, IF CHILD IS UNDER 18 YEARS) X____
DATE:_______

INSURANCE AUTHORIZATION AND ASSIGNMENT (PLEASE READ AND SIGN)
I HEREBY AUTHORIZE STARK MEDICAL SPECIALTIES, INC. TO FURNISH INFORMATION TO THE INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENT AND HEREBY ASSIGN TO THE PHYSICIAN(S) ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDANTS.

Do you have a Living Will? _____Y _____N **Do you have a Durable Power of Attorney for Healthcare? _____Y _____N**

If no, would you like us to provide you with Living Will forms? _____Y _____N and/or DPOAH: _____Y _____N

SIGNATURE:____ DATE:________________________________