



Aric J. Eckhardt, MD, FACS

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Moline, IL 61265-6180

(309) 764-4650

PATIENT INFORMATION

NAME (Last, First Middle)		MRN	SSN#	BIRTHDATE	LANGUAGE	SEX
LOCAL ADDRESS		SECONDARY/BILLING ADDRESS (if Applicable)				
CITY, STATE ZIP	HOME PHONE	CITY, STATE ZIP	HOME PHONE			
PRIMARY CARE PHYSICIAN	REFERRING PHYSICIAN	CONTACT NAME			CONTACT HOME PHONE	
PRIMARY EMPLOYER		SECONDARY EMPLOYER (if Applicable)				
ADDRESS		ADDRESS				
CITY, STATE ZIP		CITY, STATE ZIP				
WORK PHONE		WORK PHONE				

RESPONSIBLE PARTY INFORMATION (if Different than above)

NAME (Last, First Middle)		SSN#	BIRTHDATE	LANGUAGE	SEX	
LOCAL ADDRESS		SECONDARY/BILLING ADDRESS (if Applicable)				
CITY, STATE ZIP		CITY, STATE ZIP				
HOME PHONE		HOME PHONE				
RELATIONSHIP TO PATIENT						

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY		POLICY#			
NAME OF INSURED		GROUP#			
ADDRESS OF INSURANCE COMPANY		COPAY AMT		\$	
CITY, STATE ZIP		DEDUCTIBLE		\$	
RELATIONSHIP TO PATIENT		EFFECTIVE DATE		EXPIRATION DATE	

SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY		POLICY#			
NAME OF INSURED		GROUP#			
ADDRESS OF INSURANCE COMPANY		COPAY AMT		\$	
CITY, STATE ZIP		DEDUCTIBLE		\$	
RELATIONSHIP TO PATIENT		EFFECTIVE DATE		EXPIRATION DATE	

Regardless of my insurance, Medicare, or third party liability, I understand I am financially responsible for all fees for services rendered and that payment in full by me and/or a third party is expected no more than 90 days after the date of service, unless arrangements have been made with the billing office. In the event collection efforts are undertaken to obtain payment, I am personally liable for all costs incurred as a result of said collection, including the payment of reasonable attorney's fees and costs of any such action. I hereby authorize Dr. Aric Eckhardt the use of a photocopy of my signature to file claims with medicare and/or my insurance company. I hereby authorize Dr. Aric Eckhardt to release information to my referring physician. I hereby authorize and direct payment of check(s) for benefits due me for services rendered by Dr. Aric Eckhardt to be made directly to him.

SIGNATURE OF PATIENT/GUARDIAN

DATE