



Dr. Eckhardt

P O Box 263
Davenport, IA 52806
(309) 779-4650

PATIENT INFORMATION

NAME (Last, First Middle)		SSN#	BIRTHDATE	SEX
LOCAL ADDRESS		SECONDARY/BILLING ADDRESS (if Applicable)		
CITY, STATE ZIP		CITY, STATE ZIP		
HOME PHONE		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	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, if any, I understand I am financially responsible for the fees for services rendered. I authorize release of information to my referring physician. I further agree that in the event collection efforts are undertaken to obtain payment from me, that 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 to release any information regarding services rendered by him and allow a photocopy of my signature be used to file insurance or Medicare. I hereby authorize and direct payment check(s) for benefits due me for the services rendered by Dr. Aric Eckhardt to be made directly to him. Work Related: YES NO

SIGNATURE OF PATIENT/GUARDIAN

DATE

PATIENT INFORMATION CLAIMS A COPY OF INSURANCE CARD(S) IS REQUIRED FOR PROCESSING OF ALL

Name (Last, First, Middle)	Employer
Occupation	Employer Address
Referring Physician	Cell Phone
Name of Spouse	Spouses Occupation & Employer
Primary Insurance Policy Holder Employer	Primary Insurance Policy Holder Employer Address

SECONDARY INSURANCE INFORMATION

Name	Employer
Work Phone	Employer Address
Social Security #	Date of Birth
Emergency Contact (Name, Phone #)	Billing Address

Is your injury due to one of the following: (Circle if applies)

Workers Comp	Auto Accident	Liability Accident
Date of Injury		Claim #
Employer/Responsible Party		Last Date of Work
Employer/Responsible Party Address		Employer Responsible Party Telephone
Work Comp/Accident Insurance Carrier		Insurance Address:
Contact Person		Insurance Phone:
Name of Attorney		Attorney Phone #
Attorney Address		
Patient Signature		Date

How did you hear about Dr. Eckhardt:

Web Site
 Trinity In Touch
 Seminar
 Other (List)
 Emergency Room
 Chamber of Commerce
 Work
 Friend/ Family (Name)
 Doctor (Name)
 Newspaper
 Argus/Dispatch
 Quad City Times
 River City Reader
 Q.C. Magazine
 Television
 KWQC – CH 6
 WQAD- CH 8
 FOX – CH 7
 WHBF – CH 4
 Telephone Book
 Ameritech/SBC
 U.S. Qwest Dex
 Yellow Book
 Other

SMOKING CONTRACT

Studies have shown cigarette smoking may inhibit normal healing of wounds or incisions. As a patient of Dr. Eckhardt's, I agree to stop smoking and/or avoid second hand smoke at home and/or work for at least four weeks before and four weeks after any procedure. I understand that by not doing so, I may jeopardize my outcome and increase my risk of complications.

Patient Signature _____ Date _____