

Mark Janusz Smolenski, M.D.
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Mountain View, CA 94040

FILL OUT COMPLETELY. IF INCOMPLETE, CLAIMS WILL NOT BE PROCESSED AND YOU WILL BE RESPONSIBLE FOR CHARGES

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle: _____

Date of Birth: _____ Social Security Number: _____ Sex: M ___ F ___ Marital Status: _____

Home Address: _____ City: _____ Zip: _____

Home Ph: () _____ Cell Phone: () _____ Email: _____

Employer Name: _____ Work Number: _____

INSURANCE INFORMATION (ATTACH COPY OF INSURANCE CARD FRONT AND BACK)

Primary Insurance: _____ Type of plan: _____

Insurance Address: _____ City/State/Zip: _____

Insured Name: _____ Relation to patient: _____

Insured Date of Birth: _____ Insured Social Security Number: _____

ID#: _____ Group #: _____ Effective Date: _____

Insurance Phone #: _____ Employer: _____

Secondary Insurance: _____ Type of plan: _____

Insurance Address: _____ City/State/Zip: _____

Insured Name: _____ Relation to patient: _____

Insured Date of Birth: _____ Insured Social Security Number: _____

ID#: _____ Group #: _____ Effective Date: _____

Insurance Phone #: _____ Employer: _____

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above listed insurance company and I assign all insurance benefits directly to Mark Janusz Smolenski, MD, if any, otherwise payable by me for services rendered. I understand that I am financially responsible for all charges whether paid by the insurance or not. I hereby authorize the doctor/clinician to release all information necessary to secure the payment of benefit. By signing this form you agree to receive recurring messages from Mark Janusz Smolenski, M.D. Reply STOP to Opt out. Reply HELP for help. Message frequency varies. Message and data rates may apply. Carriers are not liable for delayed or undelivered messages.

SIGNATURE OF RESPONSIBLE PARTY

RELATIONSHIP

DATE SIGNED

Note: Please contact C.D. Billing Services for all billing and payment questions.

Telephone: (888) 570-1020 Fax: (888) 570-1021