Antonio M. Bird, MD, PA
5B Doctors Park
Asheville, NC 28801

Today's Date_____

# PATIENT INFORMATION

First Name_____ M.I.___ Last Name_____ Mr./Ms./Mrs./Dr.

Prefer to be called_____ Date of Birth_____ SSN_____

Address_____

Phone (home)_____ (work)_____(cell)_____

If we need to contact you at home or work may we leave a message? _____Yes _____No

Special instructions_____

Referral Source_____Place of employment_____

Is your condition work-related? _____Yes _____No

Name of primary care physician_____

Address/Tel._____

Do we have your consent to release information to this physician? _____ Yes _____No

Signature for Consent_____

Emergency Contact Name_____ Relationship_____

Address_____

Phone (home)_____ Phone (work)_____

Who is financially responsible for this bill? _____

How will you be paying today? _____Cash _____Check _____Visa/Master Card

Card type _____ Credit card number _____

Name on card _____ Expiration date _____

Billing address _____

Will you be filing insurance? _____Yes _____No If "yes," this is my authorization to release any information necessary to insurance companies in order to process payment on this account or to authorize payment for medications prescribed.

Signature_____

**NOTE TO MEDICARE PATIENTS:** This office does not participate in the Medicare program. If you would like to receive services, with the understanding that the cost of those services will not be covered by Medicare, then a separate Medicare Private Contract must be executed before services can be provided.