WC

PLEASE PRINT

Robert Bruce Miller MD

2557 Mowry Avenue, Suite 22
Fremont, CA 94538
510-795-7746 Fax 510-795-7710

Date ______ Account No. ______

☐ Consult ☐ Exam and Treat ☐ 2nd Opinion

PATIENT

Last Name ______ First Name ______ M.I. ______ Sex M F

Date of Birth ______ Age ______ Marital Status M W D S SEP Social Security # ______ Driver's License # ______

Address ______ Home Phone ( )

Address ______ Work Phone ( )

City ______ State ______ Zip ______ Cell Phone ( )

Employer ______ Employer Fax ( )

Employer Address ______ Occupation ______

City ______ State ______ Zip ______ **Date of Injury (MANDATORY)** ______

Referring Doctor ______ Address ______

INDUSTRIAL INSURANCE CARRIER INFORMATION

Carrier Name ______ Phone ( )

Address ______ Fax ( )

City ______ State ______ Zip ______ Claim # ______

Claims Adjuster/ Nurse Case Manager ______

The practice of Robert Miller is frequently subject to emergencies. Although we try to maintain our office schedule, there are times when we must reschedule appointments. For this reason, it is very important that we have a phone number where you can be reached or where a message can be left.

Daytime phone number for emergencies: ( )

I hereby authorize Robert Bruce Miller, MD, Inc. to furnish the above-mentioned insurance company all information which said insurance company may request. In the event this claim is denied by my workers' compensation carrier, I will supply Robert Bruce Miller, MD, Inc. with my private insurance information and will be held financially responsible for all charges.

If you cannot keep your future appointments, notify the office at least 24 hours in advance.

Patient or Guardian Signature ______ Date ______