Avie Health and Wellness
Martin D. Louie, M.D.
Welcome!

Please print and complete all sections

Last Name:	How would you like to be addressed: Mr. Mrs. Ms. Dr. Miss Reverend ________	
First Name:	Middle Name:	
Address:		
City:	State:	Zip Code:
Home Phone:	Cell Phone:	
Work Phone:	E-mail:	
Employer:	Occupation	
D.O.B.: Age:	Sex: Male Female	
Status: Married Single Divorced Widowed Child/Teen (Must be accompanied by legal guardian)		
Circle One: PPO Insurance Medicare Self -Pay No Insurance HMO(self-pay) EPO(Self pay)		
Insurance:	Policy #:	
Relationship to subscriber: Self Spouse Child Other:		
Subscriber:	SSN#:	D.O.B.:
Emergency Contact:	Phone #	Relationship:
Your Pharmacy (Name, Phone#, Location):		
How did you hear about us:		

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I hereby assign my insurance benefits to be made directly to my physician for services rendered. I hereby attest that the above insurance information is accurate and that I am an eligible member. I understand that I am responsible for knowing my benefits/coverage. I will be financially responsible for all charges that are not covered by my insurance company. MEDICARE PATIENTS ONLY: I understand that Medicare requires my signature on file authorizing my doctor to file claims for me and to release information to Medicare if they require it for proper processing of a claim. I authorize release of all information to the Social Security Administration and Health Care Financing Administration or its intermediaries for related medical claims. I authorize the assignment of medical service payments directly to my doctor's office. MEDIGAP ONLY: I authorize Medigap benefits to be made directly to my doctor's office for my medical care and release of any information required.

Present your insurance card and driver's license for copies to be made and kept on file.

Co-pays, deductibles and co-insurance are to be paid at time of check-in.

_______________________________ _______________________
Signature (if minor-legal guardian) Date