Richard Douglas Iliff, M.D.Fellow, American Academy of Family Physicians

Full Legal Name (As it appears on insurance files or or	NameDate of Birthears on insurance files or other form of identification, INCLUDING middle initial)		Sex	
Address		•	,	Zip
Home Phone		Race	Sex	_
Mothers Name		Fathers Name		
SS#	DOB	SS#	DOB	
Home Phone		Home Phone		
Work Phone		Work Phone		
Cell Phone		Cell Phone		
Responsible Party		Relationship		
Address		City	State	_Zip
<<<<<<<<<<	<<<<<<	<<<<>>>>>>	·>>>>>>>	·>>>>
► Primary Medical Insurance Co		Policy Holder	Date of Birth	
Policy Holder's Social Security#		Relationship to patien	ntPolicy	#
►2ndary Medical Insurance Co		Policy Holder	Date	e of Birth
2ndary Policy Holders SS#		_ Relationship to Patient	Policy #	
Religious Preference	-	Pharmacy Preferen	ice	
Emergency Contact		Relationship		
Home Phone		Work Phone		
Note to Parent or Guardian:				
Please be sure that the information provide therefore my bills are ultimately your responsible acknowledges that you will be responsible.	onsibility. If y	our insurance will not pay for wh		
Signature of Parent or C	Guardian		Date	
Treatment of a Minor without Parent or	Guardian:			
I authorize necessary medical treatm	ent for this pa	tient in my absence.		
Signature of Parent or G	uardian		Date	