

PATIENT INFORMATION FORM

Patient's Name: _____ Social Security #: _____
Address: _____ Date of Birth: ___/___/___ Age: _____ Sex: ()M ()F

Marital Status: ()S ()M ()D ()W E-MAIL: _____
Name of Parent or Guardian (if patient is a minor) Phone (H): _____

(W): _____
(C): _____
Referring Doctor: _____ Employer: _____
Address: _____ Occupation: _____

Emergency Contact: _____
Referring Doctor's Phone: _____ Emergency number: _____
Primary Doctor: _____ Pharmacy # _____
Primary Dr's Phone # & Address _____

PRIMARY INSURANCE

SECONDARY INSURANCE

Insurance Co: _____	Insurance Co: _____
Policy #: _____	Policy #: _____
Group #: _____	Group #: _____
Insured's SS# _____ If other than patient's Insured's name: _____ If other than patient's Relationship to Patient: _____ Insured Date of Birth: _____ Name of Company: _____ If other than patient's	Insured's SS# _____ If other than patient's Insured's name: _____ If other than patient's Relationship to Patient: _____ Insured Date of Birth: _____ Name of company: _____ If other than patient's

ATTENTION

We participate in the following:

Aetna/US Healthcare	HIP	Multi-plan	PHS (Healthnet)
America's Health Plan	Ind. Health	Oxford	Selectpro
Chubb	Magnacare	One Health Plan	United Healthcare
Cigna	Medicare	PHCS	

I hereby authorize Paul Hammerschlag, M.D. to furnish information concerning my illness and treatment to my insurance carriers.

I authorize payment of medical benefits to Paul Hammerschlag, M.D.

I understand that I am responsible for getting a pre-certification number from my Physician if needed.

I understand that I am responsible for any part of the charges that are not covered by medical coverage.

SIGNATURE: _____ DATE: _____

(Parent or Guardian if patient is a minor)