Complete the form online.
Then FAX or bring to your
office visit.

PATIENT INFORMATION FORM

Patient's Name:______________________________

Address: ___________________________________

____

Name of Parent or Guardian (if patient is a minor)

____

Social Security #: ____________________________

Date of Birth: ___/___/___ Age: _________ Sex: ( )M ( )F

Marital Status: ( )S ( )M ( ) D ( )W E-MAIL:_______________

Phone (H): ___________________________

(W): ___________________________

(C): ___________________________

Referring Doctor:___________________________

Address: ___________________________________

____

Referring Doctor's Phone: ____________________

Primary Doctor:____________________________

Employer: ____________________________________

Occupation: ____________________________________

Emergency Contact: _________________________________

Emergency number: __________________________

Pharmacy # ____

Primary Dr's Phone # & Address ____

PRIMARY INSURANCE

Insurance Co: _____________________________

Policy #: _________________________________

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

SECONDARY INSURANCE

Insurance Co: _____________________________________

Policy #: ____

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

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)