

PATIENT INFORMATION

- Welcome to the office -

please print

Last Name:	First Name:	MI:	Preferred Name:
Street Address:			
City:	State:	Zip Code:	
Phone (home): () -	Phone (work): () -	Phone (cell): () -	
Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male	E-mail Address:		
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Married (spouse's name):	SSN: - -	Birth Date: - -	
	Employer's Name:		
Referred By: <i>Name</i>	Occupation:		

EMERGENCY CONTACT(S)

Emergency Contact Name: <i>Primary</i>		Relationship:	
Phone (home): () -	Phone (work): () -	Phone (cell): () -	
Emergency Contact Name: <i>Secondary</i>		Relationship:	
Phone (home): () -	Phone (work): () -	Phone (cell): () -	

INSURANCE INFORMATION

Enrolled in Medicare: <input type="checkbox"/> No <input type="checkbox"/> Yes (please complete a <i>Patient-Physician Medicare Opt Out Contract</i>)
Primary Insurance: <i>Company, Address, Phone Number, Effective Date, Group #, ID #</i>
Secondary Insurance: <i>Company, Address, Phone Number, Effective Date, Group #, ID#</i>

INSURANCE AUTHORIZATION and ASSIGNMENT

<i>I request payment of authorized insurance company benefits to be made payable to Miles Hassell, M.D. or Angela Hahn, M.D. for any services furnished to myself by said physician(s). I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agent any information needed to determine these benefits or the benefits payable to related services. I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown.</i>	
Signature:	Date: