

PATIENT INFORMATION SHEET

Please print carefully.

NAME : _____

BIRTH DATE : _____ **AGE :** _____ **SEX :** M F

HOME ADDRESS : _____

CITY : _____ **ZIP :** _____

HOME TELEPHONE : _____ Can we leave a detailed message Y N

CELLPHONE : _____ Can we leave a detailed message Y N

MARITAL STATUS : Single Married Divorced Widow(er) Domestic Partner

SOCIAL SECURITY : _____ **DL :** _____

EMPLOYER : _____

OCCUPATION : _____

BUSINESS ADDRESS : _____

WORK PHONE : _____

NAME OF SPOUSE/PARTNER : _____

BIRTH DATE : _____ **SSN:** _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____

Subscriber ID: _____ **Group #:** _____

Claims Address: _____

REFERRED BY: _____

PRIMARY DOCTOR : _____ **PHONE :** _____

EMERGENCY CONTACT : _____ **PHONE:** _____

ASSIGNMENT OF BENEFITS

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some insurance companies pay fixed allowances for certain procedures while others pay a percentage of the charge. It is your responsibility to pay any deductible, co-insurance, or any balance not paid for by your insurance. I here by assign all medical and/or surgical benefits to include medicare, private insurance, and other health plans to which I am entitled to Cynthia Hall, MD. I understand that I am financially responsible for all charges, whether or not paid by my insurance. I hereby authorize said assignee to release all information necessary to secure the payment and that a photocopy of this assignment is to be considered as valid as an original. If it becomes necessary for the account to be referred to an attorney for collection or suit, the undersigned shall pay the reasonable attorney fees and collection expenses.

Signature : _____ **Date:** _____