Welcome to our office. Please complete this form and return it to our receptionist. Please provide your insurance card for a copy.

Informacion Personal: **Fecha: ____/____/ 0**

Nombre: ____

De Tele ____________________ # de Trabajo ________________________________

Direcion: ____

____

Ciudad *Estado* *Area Postal*

Sexo: M F Marital Status: Single Divorced Married Widowed

SS#: __________________ Fecha de Nacimento: _________________ Edad: ________

Empleo: ____

(If retired, please list previous employer)

Direcion Empleo: ____

____

Posision: ___________________________________ Full or Part time / Retirado

En caso de emergencia por favor notificar: ______________________________________

Relacion a La persona: ____________________ #de Tele____________________

Person's Address: ____

Informacion de Esposo/Esposa:

Nombre: ____________________ Edad: _____ Fecha de Nacimento_________________

SS#: _______________________ Daytime Phone # ______________________

Empleo y Direcion: ____

____

{See es tetirado, por favor ponga ultimo emplo}

Esta usted cubrido por el seguro de su esposo/ esposa ? Yes No

MEDICAL INFORMATION:

La visita De Hoyes Relacionado A Lo Siguiente: (Please circle one)

Problema Medical ida Relacionado a Trabajo

Relacionado a un accidente Erida de Motor Vehiculo

Quien Lo Refirio a Nuestra Oficina____

Nombre de Medico Familiar____

Direcion_______________________ Ciudad: ____________________________

#de Tele: _____________________________

Insurance Information:

Que Tipo de Seguro tiene?

Commercial Medicare Medicaid HMO/PPO None

Seguro Primario: ____

Direcion: ____

Nombre de La Persona tiene el seguro: ______________________Relacion al Paciento: ____________

ID# ____________________________

Seguro Secundario y #de La Policy: ________________________________

Direcion: ____

Persona Financial Mente Responsible par Esta Cuenta:

____
(Su Nombre)

____
(Su Fima)

You will be responsible for your yearly deductible and your co-payment (20% for Medicare patients) at the time of service. As a courtesy, our office will file your claim with a secondary insurance carrier if it is a Medigap Participant.

I authorize any holder or other information about me to release to my insurance carrier or to the Centers For Medicare and Medicaid Services (CMS) or its agents, intermediaries or carriers, any information, including medical, needed to process this claim or a related Medicare claim. I hereby assign all medical and/or surgical benefits to which I am entitled, including Medicare and other government sponsored programs, private insurance or any health plan to: James E. Haberman, MD. I permit a copy of this authorization to be used in place of the original. This shall serve as a lifetime authorization, including Medicare.

_______________________________ _____/_____/ 0___
Firma de Pociente Fecha