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

## Personal Information: Date: ____/_____/_____

Name: _____ _____
Last First

Home Phone # _____ Work Phone # _____

Cell Phone # _____

Mailing Address: _____
(No P.O. Box)

_____
*City* *State* *Zip*

Sex: M F Marital Status: Single Divorced Married Widowed

SS#: _____ Date of Birth: _____ Age: _____

## Insurance Information:

What type of insurance do you currently have?

Medicare Medicaid Other None

Primary Insurance Carrier: _____

Policyholder's Name: _____ **Date of Birth**:_____/_____/_____

ID# _____ Relationship to patient: _____

Secondary Insurance Carrier: _____

Policyholder's Name: _____ **Date of Birth**:_____/_____/_____

ID#: _____ Relationship to patient: _____

Employer: _____
*(If retired, please list previous employer)*

Employer's Address: _____

_____

Occupation: _____ Full or Part time / Retired

In case of emergency, please notify: _____

Person's relationship: _____ Phone # _____

Person's Address: _____

## Information about Spouse:

Name: _____ Age: _____ Date of Birth_____

SS#: _____ Daytime Phone # _____

Employer and Address: _____

_____
*(If retired, please list previous employer)*

Are you covered by spouse's insurance? Yes No

You were referred by: _____

Name of Your Family Physician: _____

Address: _____ City: _____

Phone #: _____

## MEDICAL INFORMATION:

Today's visit is related to the following: (Please circle one)

Medical Problem Work Related Injury

Accident Related Motor Vehicle Injury

## Person Financially Responsible for this Bill:

_____
(Please Print)

_____
(Signature)

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.

_____ _____/____/_____

Patient's Signature Today's Date