Welcome to our office! Please complete this form in <u>black ink only</u> and return it to our receptionist. Please provide your insurance card & photo ID for a copy.

<u>Personal Information:</u> Date: ____/____/21

Name: _____ _____
Last First

Home Phone # _____ Cell Phone # _____

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

_____
City *State* *Zip*

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

Sex: M F Marital Status: Single Divorced Married Widowed

Language: _____ Ethnicity: _____ Race: _____

<u>Insurance Information:</u>

What type of insurance do you currently have?

Medicare Medicaid Other None

<u>Primary</u> <u>Insurance</u> <u>Carrier</u>: _____

Primary Subscriber's Name: _____ **Date of Birth**:_____/_____/_____

ID# _____ Relationship to patient: _____

<u>Secondary</u> <u>Insurance</u> <u>Carrier</u>: _____

Primary Subscriber's Name: _____ **Date of Birth**:_____/_____/_____

ID#: _____ Relationship to patient: _____

<u>Employer Information:</u>

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: _____

<u>Information about Spouse:</u>

Name: _____ Age: _____ Date of Birth_____

SS#: _____ Daytime Phone # _____

Employer and Address: _____

_____

(If retired, please list previous employer)

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

Person Financially Responsible for this Bill:

_____
(Please Print)

_____
(Signature)

MEDICARE PATIENTS PLEASE KEEP IN MIND: You will be responsible for your yearly deductible and your co-payment/co-insurance (20%) at the time the service is rendered. As a courtesy, our office will file your claim with a secondary insurance carrier if it is a Medigap Participant.

I 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. Any outstanding balance that is sent for collections will be charged an additional $75 fee.

_____ _____/_____/21__

Patient's Signature Today's Date