STUART J. FISCHER M.D.

Account # ___________

PATIENT INFORMATION 2020

Patient Name: Last ________________________________ First ________________________________ Middle Initial _____

Date of Birth _____/_____/_________ SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___ Marital Status _________

Spouse's Name ________________________ Parents' Name(s) ________________________ ________________________

Home Address ____City ____________________ State _______ Zip __ __ __ __ __

HOME PHONE ( ) ___________________ CELL ( ) _____________________ WORK ( ) _________________

Occupation ___________________________ Race ____________ Ethnicity ____________ E-mail ________________________

(please write Yes or NO) Do you currently smoke? _____ Are you a former smoker? _____ Do you regularly use chewing tobacco? _____

Ht ___ ___ Wt ______ Drug Allergies __________________________Pharmacy Name/Location____________________________

Medications (include dosage) ____

Reason for visit ____

Designated Individual for Release of Medical Information ____

Relationship to Patient _________________________ Telephone ( )____

INTERNIST/PRIMARY CARE PHYSICIAN: _______________________ Telephone ( ) ____________________

REFERRED TO DR. FISCHER BY: _______________________________ Telephone ( ) ____________________

	PRIMARY INSURANCE	SECONDARY INSURANCE
INSURANCE COMPANY		
POLICY NUMBER/ MEMBER ID		
GROUP NUMBER		
POLICY HOLDER		
RELATIONSHIP TO PATIENT		
DATE OF BIRTH OF POLICY HOLDER		
SOCIAL SECURITY NUMBER OF POLICY HOLDER		
NAME OF EMPLOYER		
EMPLOYER'S FULL ADDRESS AND ZIP CODE		

WORKER'S COMP/AUTO ACCIDENT

(please write yes or no)

Is this a Worker's Compensation case? _____ Motor Vehicle Accident? _____ Date of Accident _____________

Insurance Carrier ____ Claim # ______________________________

Insurance Company Address: ____

Telephone ( ) ___________________________ Adjuster____

I hereby authorize my insurance benefits to be paid directly to Dr. Stuart Fischer. I understand that I am financially responsible for any non-covered services. I agree that if my account is put in a collection account an additional collection fee in the amount of $150 will be due and payable immediately along with any additional attorney fees and costs that are incurred. I also authorize the physician to release any medical information that is required to secure the payment of benefits. I have read the HIPPA practices posted for this office.

SIGNED: x ____ **DATE:** ____________________2020