STUART J. FISCHER M.D.

Account # _____

PATIENT INFORMATION 2021

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 $250 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:** _____ **2021**