

PATIENT INFORMATION 2022

Patient Name: Last _____ First _____ Middle Initial _____

Date of Birth ____/____/____ SS# _____ - _____ - _____ Marital Status (M S D W) _____

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: _____ 2022