

# PATIENT INFORMATION RECORD

DATE	REFERRED BY/ADDRESS IF KNOWN	ACCOUNT NUMBER
		<b>L H</b>
FAMILY PHYSICIAN/ADDRESS IF KNOWN		

## PATIENT AND FAMILY INFORMATION

LAST NAME	FIRST	MIDDLE	AGE	SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX
SPOUSE'S LAST NAME	FIRST	MIDDLE	AGE	SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX
ADDRESS: NUMBER AND STREET			CITY	STATE	ZIP	
HOME PHONE			WORK PHONE			
EMAIL			CELL PHONE			
MARITAL STATUS						
M   S   D   W						

## RESPONSIBLE PARTY *(Please complete if patient is a minor or covered by spouse)*

IF OTHER RESPONSIBLE PARTY, SUCH AS SPOUSE OR PARENT OR OTHER RELATIONSHIP, PLEASE INDICATE NAME, RELATIONSHIP AND ALTERNATIVE BILLING ADDRESS:

NAME: LAST	FIRST	MIDDLE	AGE	SOCIAL SECURITY NUMBER	DATE OF BIRTH
ADDRESS: NUMBER AND STREET			CITY	STATE	ZIP
					PHONE

## INSURANCE INFORMATION *(Please present your insurance card(s) to Registration)*

PRIMARY INSURANCE COMPANY NAME AND ADDRESS:			SECONDARY INSURANCE COMPANY NAME AND ADDRESS:			
EMPLOYEE/SUBSCRIBER NAME:		DATE OF BIRTH	EMPLOYEE/SUBSCRIBER NAME:		DATE OF BIRTH	
I.D. OR CERTIFICATE NUMBER / GROUP NUMBER		EFFECTIVE DATE	I.D. OR CERTIFICATE NUMBER / GROUP NUMBER		EFFECTIVE DATE	

## IF VISIT IS RELATED TO INJURY:

PERSONAL INJURY?  
  AUTO ACCIDENT?  
  WORK RELATED?  
  OTHER \_\_\_\_\_  
 DATE OF INJURY: \_\_\_\_\_

INSURANCE NAME AND ADDRESS	EMPLOYER/RESPONSIBLE PARTY	CLAIM NUMBER

## EMERGENCY NOTIFICATION *(Other than above):*

IN CASE OF EMERGENCY, PLEASE CONTACT: \_\_\_\_\_ ADDRESS \_\_\_\_\_

NAME:		
RELATIONSHIP	DAYTIME PHONE	EVENING PHONE

## FINANCIAL INFORMATION

If we are contracted with your insurance carrier we will bill them directly. You will be required to pay your portion of the charges and/or copayment on the day the services are rendered. If we are not contracted with your insurance carrier, you will be required to pay the total charges on the day the services are rendered. As a courtesy to you, we will submit the initial insurance bill to your carrier.

**INSURANCE RELEASE:** I hereby authorize Dr. Daryl Hoffman and Daryl K Hoffman, M.D., Inc. to furnish my Insurance Company with all information which they may require concerning my illness/injury for reimbursement for services rendered.

**ASSIGNMENT OF BENEFITS:** I hereby assign to Dr. Daryl Hoffman and Daryl K. Hoffman, M.D., Inc. my benefits for my medical and surgical services. A photocopy of the authorization is as valid as the original.

**I HEREBY GUARANTEE PAYMENT IN FULL OF ANY AND ALL CHARGES IN CONSIDERATION FOR MEDICAL SERVICES RENDERED, OR TO BE RENDERED.**

X \_\_\_\_\_ Date \_\_\_\_\_  
 Responsible Party Signature