PATIENT GENERAL INFORMATION SHEET

Patient Information

◯ M ◯ F Marital Status ________ Birthdate ________ Referred By ________

Last Name ________ First Name ________ Middle ________ SS# ________

Address ________ Apt # ________ City ________ State ____ Zip ________

Home # ________ Work # ________ Cell # ________ Preferred # to Call ________

Email Address ________

Race ________ Ethnicity ________ Preferred Language ________

Employer Name ________ Address ________ City ________ State ____ Zip ________

Pharmacy Name ________ Address ________ City ________ Phone # ________

Patient Record of Disclosure

Home Phone: ◯ OK to leave message with detailed information ◯ Leave message with call-back number only

Work Phone: ◯ OK to leave message with detailed information ◯ Leave message with call-back number only

Cell Phone: ◯ OK to leave message with detailed information ◯ Leave message with call-back number only

Emergency Contact: ________

Written Communication: ◯ OK to mail to home address ◯ OK to mail to work /office ◯ OK to fax to this number Other ________

Primary Care Physician: ________

Name Phone Address City State Zip Code

Referring Physician: ________

Name Phone Address City State Zip Code

Is this appointment work or auto related? If yes, Claim # ________ Ins. Co. ________ Phone ________

Primary Insurance

Name of Insurance ________ Referral Needed ◯ Yes ◯ No CoPay ________

Policy holder's Last Name First Name Middle Date of Birth SS #

Insurance Contract # Group # Phone # Address City State Zip

Subscriber's Address (if different than patient) City State Zip Phone #

Secondary Insurance

Name of Insurance ________ Referral Needed ◯ Yes ◯ No CoPay ________

Policy holder's Last Name First Name Middle Date of Birth SS #

Insurance Contract # Group # Phone # Address City State Zip

Subscriber's Address (if different than patient) City State Zip Phone #

Authorization and Release

I certify that I have read and understood the above information to the best of my knowledge. I authorize the release of all medical records to health professionals and my insurance company. I acknowledge full financial responsibility for services rendered by Raymond T. Hajjar, D.O. I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges. I authorize and request that insurance payments be made directly to Raymond T. Hajjar, D.O. I have read and fully understand the above consent for treatment and financial responsibility, release of medical information and insurance authorization.

☐ Please check this box if you **do not** wish to receive information on specials or events.

Patient's Name ________ Date ________ Guardian's Name ________

(If patient is a minor)