

PLEASE PRINT AND COMPLETE ALL INFORMATION

PATIENT INFORMATION

NAME: _____ DATE OF BIRTH: _____
 LAST FIRST MIDDLE

STREET ADDRESS: _____ APARTMENT NUMBER _____

HOME PHONE() _____ CELLULAR PHONE() _____

CITY: _____ STATE: _____ ZIP: _____

SEX: M F MARITAL STATUS: M S W D SOCIAL SECURITY# _____

PATIENT'S EMPLOYER NAME: _____ WORK PHONE: () _____

EMPLOYER ADDRESS: _____

SPOUSE'S NAME: _____ WORK PHONE: () _____

PHARMACY NAME: _____ PHARMACY PHONE: () _____

EMERGENCY CONTACT: _____ PHONE: () _____

REFERRED BY: _____

INSURANCE INFORMATION

PRIMARY INSURANCE INFORMATION

RELATIONSHIP TO PATIENT: SELF SPOUSE OTHER

INSURANCE

CARRIER: _____ ID# _____ GROUP# _____

CLAIMS ADDRESS: _____ PHONE NUMBER () _____

(IF OTHER THAN PATIENT, PLEASE COMPLETE THE FOLLOWING)

INSURED PARTY NAME: _____ DATE OF BIRTH: _____

EMPLOYER: _____ SOCIAL SECURITY # _____

EMPLOYER ADDRESS: _____

SECONDARY INSURANCE INFORMATION

RELATIONSHIP TO PATIENT: SELF SPOUSE OTHER

INSURANCE CARRIER: _____ ID# _____ GROUP# _____

CLAIMS ADDRESS: _____ PHONE # () _____

PRIVATE INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS/INFORMATION RELEASE:

*I, The undersigned, authorize payment of medical benefits to A & M Sahar MD,PA for any services furnished me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company any information concerning healthcare, advice, treatment or supplies provided to me. This information will be used for the purposes of evaluating and administering claims of benefits. **** All Physical Exams Require 24 Hour Cancellation Notice To Avoid \$125.00 Charge That You As The Patient Will Be Held Liable*****

Signed: _____ Date: _____

(If child under age 18 years old, Parent/Guardian Signature)

Medicare Lifetime Signature on File:

I request that payment of authorized Medicare benefits be made on my behalf to A & M Sahar MD, PA for any services furnished to me by those physicians. I authorize any holder of medical information about me to release to the Health Care Financing Administration, its agents, and Medigap insurers any information needed to determine these benefits or the benefits payable for related services.

Signed: _____ Date: _____