PLEASE FILL OUT COMPLETELY AND SIGN WHERE INDICATED.
(PRINT AND PRESS HARD.)

ADULT

Over 18, not a full-time student.

INSURANCE AUTHORIZATION AND ASSIGNMENT

Date _____/_____/_____

PLEASE SIGN BY BOTHS X's

I authorize payment of medical benefits to undersigned physician of supplier for these services and full claims.	I authorize the release of any medical information necessary to process this claim and all future claims.
X ______________________ Signed (Insured or Authorized Person)	X ______________________ Signed (Insured or Authorized Person)

PATIENT INFORMATION

Last Name ______ First Name ______ Middle Initial ______

Street Address ______ City ______ State ______ Zip ______

Sex: (Circle one) Male Female Date of Birth _____/_____/_____ Age: __________ Home Phone ( ) _______-_________

Social Sec No: _________-_________-________ Is the Patient currently employed? (Circle one) Yes No

Employer: ______________ Employer Address: ______________

Work Phone : ( ) ______-______ Extension: __________ Cell Phone: ( ) _______-_________

Is the Patient a student? (Circle one) Yes No If Yes, name of school: ______________

Is the Patient? (Circle one) Single Married Separated Divorced Widowed

Race: (Circle one) American Indian Alaskan Native African American Native Hawaiian/Other Asian White Hispanic

Ethnicity: (Circle one) Greek Hispanic/Latino Italian Irish American Other

Primary Language: ______________________

If you circled Married, please complete Spouse information below.

Spouse's Last Name ______ First Name ______ Middle Initial ______ Nickname ______

Date of Birth: _____/_____/_____ Is the Spouse currently employed? (Circle one) Yes No

Employer: ______________ Employer Address: ______________

Work Phone: ( ) ______-______ Extension: __________ Social Sec No.: _________-_________-_________

Referring Physician: ______________ Primary Care Physician: ______________

Address: ______________ Address: ______________

Phone: ( ) _________-_____________ Phone: ( ) _________-_____________

NEXT OF KIN INFORMATION

Give the name of nearest relative or of a close friend not living with you, to contact in case of emergency.

Name: ______________ Home Phone: ______________ Cell Phone: ______________

Relationship: ______________ **Can we release medical information?:** ☐ **Yes** ☐ **No**

Is this visit related to a work injury? (Circle one) Yes No If Yes, Date of Injury: _____/_____/_____

Is this visit related to an auto accident? (Circle one) Yes No If Yes, Date of Accident: _____/_____/_____

WORKER'S COMPENSATION OR NO FAULT INSURANCE ONLY

Insurance Company: ______________________

Ins. Co. Address: ______________________

City: ______________ State: __________ Zip: __________

Adjuster Phone: ( ) __________-____________________

Employer: ______________________

Claim No.: ______________________

Adjuster Name: ______________________

Pharmacy Name: ______________________

Pharmacy Phone: ______________________

I allow Hartzband Center to download my E-Med electronic medication history.

X

Signature