

PLEASE PRINT

Name of Patient _____ SS# _____
Address _____ Date of Birth _____
City _____ State _____ Zip _____ M/F Age _____
Home Telephone () _____ Cell Phone () _____ Pager () _____
E-Mail _____
Employer _____ Telephone () _____
Address _____ Occupation _____
Purpose of today's visit: _____ Referred By _____

Is this visit due to an injury? Yes No Date of Injury ____
Was this an on the job injury Yes No

IF PATIENT IS UNDER 18...COMPLETE THE FOLLOWING:

Relationship to Patient _____
Name of Responsible Party _____
Address _____
Home Telephone () _____ Work Telephone () _____
Name of Employer _____
Address _____

Please submit insurance card(s) and picture ID to receptionist with this form

PRIMARY Insurance _____ SECONDARY Insurance _____
Subscriber Name (if other than patient) _____ Subscriber Name (if other than patient) _____
Relationship to Patient Spouse Child Other _____ Relationship to Patient Spouse Child Other _____
Subscribers SS# _____ Date of Birth _____ Subscribers SS# _____ Date of Birth _____

I hereby authorize my insurance benefits to be paid directly to Fred H. Siegel, M.D.
I hereby authorize Fred H. Siegel, M.D. to release any information acquired in the course of my examination or treatment.
I hereby authorize any physician, hospital, or medical facility to provide all information on my medical history and treatment to Fed H. Siegel, M.D.

Date _____ Patient / Insured's Signature _____