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 _____