PATIENT INFORMATION RECORD
PLEASE PRINT LEGIBLY

DATE OF INJURY OR DATE SYMPTOMS STARTED: ____________ DATE TODAY: ___________

PATIENT FIRST NAME MIDDLE INITIAL	LAST NAME	SINGLE	WIDOWED
		MARRIED	DIVORCED
STREET ADDRESS	CITY, STATE, ZIP CODE	TELEPHONE NUMBER ( )	
BIRTHDATE AGE	PATIENT'S SOCIAL SECURITY NUMBER	PATIENT'S CELL NUMBER ( )	
LIST ANY OTHER NAME YOU HAVE USED	OCCUPATION	PHARMACY NUMBER ( )	
EMPLOYER	ADDRESS, CITY, STATE, ZIP CODE	EMPLOYER TELEPHONE **EXT** ( )	
SIGNIFICANT OTHER	BIRTHDATE	OCCUPATION	
EMPLOYER	ADDRESS, CITY, STATE, ZIP CODE	EMPLOYER TELEPHONE **EXT** ( )	

IF PATIENT IS A MINOR OR STUDENT:

FATHER'S NAME BIRTHDATE	ADDRESS, CITY, STATE, ZIP CODE	TELEPHONE NUMBER ( )
EMPLOYER	ADDRESS, CITY, STATE, ZIP CODE	TELEPHONE NUMBER ( )
MOTHER'S NAME BIRTHDATE	ADDRESS, CITY, STATE, ZIP CODE	TELEPHONE NUMBER ( )
EMPLOYER	ADDRESS, CITY, STATE, ZIP CODE	TELEPHONE NUMBER ( )

INSURANCE INFORMATION
MUST BE FILLED OUT COMPLETELY

PRIMARY INSURANCE ____ PHONE NUMBER _(_______)____________________

SUBSCRIBER NAME ____ EFFECTIVE DATE: ___________________________

MEMBER NUMBER ____ GROUP NUMBER _____________________________

WORKERS COMPENSATION CL# _______________________________ MCO NAME __________________________________

CLAIMS REPRESENTATIVE ____________________________________ MCO PHONE NUMBER ________________________

EMPLOYER AT DATE OF INJURY _______________________________ DATE OF INJURY ____________________________

PLEASE INTITIAL TO VERIFY ALL THE INFORMATION ABOVE IS CORRECT _____________

OVER PLEASE

ADDITIONAL INFORMATION

FAMILY PHYSICIAN ________________________________ REFERRING PHYSICIAN ________________________________

STREET ADDRESS ________________________________ STREET ADDRESS ________________________________

CITY, STATE, ZIP ________________________________ CITY, STATE, ZIP ________________________________

TELEPHONE __(______)________________________________ TELEPHONE __(_______)________________________________

EMERGENCY CONTACT INFORMATION

NAME: ________________________________ RELATIONSHIP TO YOU: ________________________________

STREET ADDRESS: ________________________________ TELEPHONE: _(______)________________________

CITY, STATE, ZIP CODE: ____

WHO IS RESPONSIBLE FOR PATIENT'S MEDICAL EXPENSES

☐ PARENT ☐ SIGNIFICANT OTHER ☐ SELF

NAME OF PARENT OR SIGNIFICANT OTHER (GUARANTOR)____

DATE OF BIRTH: ____________________ SOCIAL SECURITY NUMBER: ________________________________

GUARANTOR SIGNATURE: ________________________________ DATE: ________________

THE OFFICE OF HAL S. BLATMAN, M.D., INC WILL PROCESS YOUR PRIMARY INSURANCE CLAIM AS A COURTESY TO YOU, HOWEVER, THE GUARANTOR IS FULLY RESPONSIBLE FOR ALL CHARGES REGUARDLESS OF INSURANCE COVERAGE.

ASSIGNMENT OF INSURANCE BENEFITS:

I HEREBY AUTHORIZE ALL PAYMENTS MADE BY THE INSURANCE COMPANY TO BE PAID DIRECTLY TO HAL S. BLATMAN, M.D., INC.

PATIENT SIGNATURE: ________________________________ DATE: ________________

PARENT SIGNATURE: (IF MINOR) ________________________________ DATE: ________________.