PATIENT INFORMATION RECORD
PLEASE PRINT LEGIBLY

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

PATIENT FIRST NAME MIDDLE INITIAL	LAST NAME	SINGLE / MARRIED	WIDOWED / 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	EMAIL ADDRESS	
NAME OF INSURANCE SUBSCRIBER	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 INITIAL 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: ____

OK TO RELEASE MEDICAL OR FINANCIAL INFORMATION TO THIS PERSON? YES

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: ________________.

WHO IS RESPONSIBLE FOR PATIENT'S MEDICAL EXPENSES

☐ PARENT ☐ SELF

NAME GUARANTOR____

DATE OF BIRTH: ___________________ SOCIAL SECURITY NUMBER: ________________________________

GUARANTOR SIGNATURE: _____________________________________ DATE: ________________