PATIENT INFORMATION

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Date _____

Bus. Phone _____ Home Phone _____ Cell Phone _____

Name _____ Soc. Sec# _____

Address _____ Driver's Lic.#_ _____

City/State/Zip _____

Sex ☐ M ☐ F Age _____ Date of Birth _____

☐ Single ☐ Married ☐ Separated ☐ Widowed ☐ Divorced

Employer _____ Work phone _____

Employer address _____ Occupation _____

In case of emergency who should be notified? _____

Phone _____ Cell _____ Relationship to patient _____

How did you hear about us? _____

INSURANCE INFORMATION

Type of insurance? _____

Who is the policy holder? _____ Policy holder Date of Birth _____

Policy Holder Soc. Sec. # _____ Relationship to patient _____

SECONDARY INSURANCE

Type of insurance? _____

Who is the policy holder? _____ Policy holder Date of Birth _____

Policy holder Soc. Sec. # _____ Relationship to patient _____

ASSIGNMENT OF BENEFITS

I hereby authorize Michael A. Hochman, M.D..P.A. and his employees to release information acquired during the course of my examination and treatment to the Centers of Medicare and Medicaid Services and its agents, or any other third-party carrier as necess: to secure payment of any benefits due me. I hereby assign payment of said benefits to include insurance benefits directly to Michael Hochman, M.D., P.A. I understand that I am responsible for all charges regardless of insurance status as well as any associated costs for collection should such action become necessary. I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date. A photocopy of this assignment shall be considered as valid as the original. I have read the above and fully understand the terms thereof.

Signature _____ Date _____