

PATIENT INFORMATION

LAST NAME:		FIRST NAME:		M.I.:	
ADDRESS:		CITY:		STATE: ZIP:	
DATE OF BIRTH:		GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female		MARITAL STATUS: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widow <input type="checkbox"/> Divorced	
HOME PHONE NUMBER:			OTHER PHONE NUMBER / CELL PHONE NUMBER:		
SOCIAL SECURITY NUMBER:			SPOUSE'S NAME:		
DRIVER'S LICENSE NUMBER:			SPOUSE'S DATE OF BIRTH:		
EMPLOYER:			SPOUSE'S EMPLOYER:		
ADDRESS:			ADDRESS:		
CITY:		STATE:	ZIP:	CITY: STATE: ZIP:	
WORK NUMBER – EXT:			WORK NUMBER – EXT:		

REFERRING SOURCE

REFERRING PHYSICIAN:		TELEPHONE #:
PRIMARY CARE PHYSICIAN:		TELEPHONE#:
Do you have an Advance Directive / Power of Attorney / DNR orders filed with your Doctor's office? <input type="checkbox"/> YES, LOCATION <input type="checkbox"/> NO		

GUARANTOR / RESPONSIBLE PARTY (IF DIFFERENT THAN PATIENT)

NAME:	DATE OF BIRTH:	SOCIAL SECURITY NUMBR
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EMERGENCY CONTACT / RELATIVE / FRIEND

LAST NAME:	FIRST NAME:	M.I.:	RELATIONSHIP	HOME PHONE:
ADDRESS			CITY STATE ZIP:	<input type="checkbox"/> WORK <input type="checkbox"/> CELL PHONE:

INSURANCE INFORMATION

NAME OF PRIMARY INSURANCE COMPANY:	ADDRESS, CITY, ST, ZIP:	TELEPHONE #:
POLICY NUMBER OR MEMBER NUMBER:	GROUP NUMBER:	
NAME OF POLICY HOLDER:	RELATIONSHIP (to policy holder): <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	
DATE OF BIRTH:	SOCIAL SECURITY NUMBER:	

NAME OF SECONDARY INSURANCE COMPANY:	ADDRESS, CITY, ST, ZIP:	TELEPHONE #:
POLICY NUMBER OR MEMBER NUMBER:	GROUP NUMBER:	
NAME OF POLICY HOLDER:	RELATIONSHIP (to policy holder): <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	
DATE OF BIRTH:	SOCIAL SECURITY NUMBER:	

INSURANCE AUTHORIZATION AND ASSIGNMENT (PLEASE READ AND SIGN)

I HEREBY AUTHORIZE AARON JOSEPH, M.D., P.A. TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO AARON JOSEPH, M.D., P.A. ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES REGARDLESS OF INSURANCE COVERAGE.

SIGNATURE: _____ **DATE:** _____