PATIENT INFORMATION SHEET – PLEASE PRINT

FIRST NAME_____MI_____LAST NAME_____

SS#_____DATE OF BIRTH_____AGE_____SEX_____

PERMANENT ADDRESS_____CITY_____

STATE_____ZIP_____PHONE#_____

TEMPORARY ADDRESS_____CITY_____

STATE_____ZIP_____PHONE#_____

BUSINESS PHONE#_____CELLULAR PHONE#_____

EMPLOYER_____OCCUPATION_____

EMPLOYER ADDRESS_____

ILLNESS RELATED TO: AUTO ACCIDENT Y / N EMPLOYMENT Y / N OTHER Y / N

PRIMARY INSURANCE_____ID#_____GROUP#_____

ADDRESS_____

NAME OF INSURED PERSON(IF OTHER THAN PATIENT)_____

RELATIONSHIP_____DOB_____SS#_____

SECONDARY INSURANCE_____ID#_____GROUP#_____

ADDRESS_____

NAME OF INSURED PERSON(IF OTHER THAN PATIENT)_____

RELATIONSHIP_____DOB_____SS#_____

MARITAL STATUS: SINGLE MARRIED WIDOWER DIVORCED SEPARATED

SPOUSE'S NAME_____SPOUSE'S WORK#_____

PARTY RESPONSIBLE FOR PAYMENT IF OTHER THAN PATIENT_____

ADDRESS_____

RELATIONSHIP_____HOME#_____WORK#_____

EMERGENCY CONTACT PERSON_____PHONE#_____

WHO REFERRED YOU TO THIS OFFICE_____

PRIMARY CARE PHYSICIAN_____PHONE#_____

INSURANCE AUTHORIZATION AND ASSIGNMENT OF BENEFITS-READ & SIGN BELOW

I hereby authorize Craig Wm. Herman, M.D., P.A. and/or Steven C. Kester, M.D. to furnish insurance carriers concerning my illness and treatments and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by my insurance. A photostatic copy of this authorization shall be considered as effective and valid as the original. I authorize any doctor or hospital to release any x-rays or medical records to Craig Wm. Herman, M.D. and/or Steven C. Kester.

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Signature of Patient or Responsible Party Date