

Healthcare for Business

Date: _____

How were you referred to this practice? (Please circle one)

Primary Doctor ER Doctor Yellow Pages Internet Friend Employer

If by a physician/employer please list: _____

PATIENT INFORMATION

First Name	Middle Initial	Last Name
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Patient Mailing Address

City	State	Zip
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Home Telephone	Cell phone	Alternate phone
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Circle one: single married divorced widowed

Social Security # _____ Circle one: Male Female

Date of birth: _____ Age: _____

Employer/Occupation _____

Employer phone _____

IN CASE OF EMERGENCY CONTACT:

Name	Relation to patient
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Home telephone	Cell phone	Work phone
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If necessary, how may we contact you regarding health matters?

Home phone: _____

Work phone: _____

Cell phone: _____

May we leave a message on an answering machine re: health matters? Yes/No

May we leave a message on an answering machine re: appointments? Yes/ No

RESPONSIBLE PARTY

Primary Insurance Company _____

Primary Cardholders Name _____

Insurance Co. Address _____

Insurance Co. Phone _____

ID# _____ Group# _____

Secondary Insurance Company _____

Insurance Co. Address _____

Insurance Co. Phone _____

Spouse's Information: Name _____

SS# _____ Date of birth _____

BWC Claim Number _____ MCO _____

Employer Contact person: _____

AUTHORIZATION

I authorize Healthcare for Business to release any medical information obtained during my treatment to my medical insurance carriers and to my referring doctors. I hereby authorize payment of medical benefits to Healthcare for Business, Dr. Paul C. Hanahan.

Responsible party signature

Date

