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	EMPLOYER TELEPHONE **EXT** ( )	
SIGNIFICANT OTHER	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 INTITIAL 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: _____

WHO IS RESPONSIBLE FOR PATIENT'S MEDICAL EXPENSES

☐ PARENT ☐ SIGNIFICANT OTHER ☐ SELF

NAME OF PARENT OR SIGNIFICANT OTHER (GUARANTOR)_____

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

GUARANTOR SIGNATURE: _____ DATE: _____

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: _____.