PATIENT IDENTIFICATION DATA

PATIENT NAME_____
last first middle

ADDRESS_____
street city state zip

TELEPHONE_____ DATE OF BIRTH_____ SEX____ SOC. SEC. #_____

LIST NAMES AND BIRTHDATE OF ALL BROTHERS AND SISTERS:

_____ _____

_____

BILLING INFORMATION

MOTHER'S NAME_____ SOC. SEC.#_____

TELEPHONE_____ CIRCLE ONE: Single Married Divorced Widow Separated

ADDRESS_____

EMPLOYER_____TELEPHONE_____

FATHER'S NAME_____ SOC. SEC.#_____

TELEPHONE_____ CIRCLE ONE: Single Married Divorced Widow Separated

ADDRESS_____

EMPLOYER_____ TELEPHONE_____

INSURANCE INFORMATION

INSURANCE COMPANY_____ GROUP #_____ I.D. #_____

ADDRESS_____TELEPHONE_____

POLICYHOLDER_____RELATIONSHIP_____BIRTHDATE_____

SECOND INSURANCE CO._____GROUP #_____ I.D. #_____

ADDRESS_____TELEPHONE_____

POLICYHOLDER_____RELATIONSHIP_____BIRTHDATE_____

REFERRED BY: ___physician? who?_____neighbor? who?_____newspaper?_____phonebook?____

I hereby consent to allow Dr. Fandel or his associates to medically treat my child (or myself). I hereby agree to be financially responsible for office or hospital charges incurred by the above named patient payable to Dr. Fandel. I hereby authorize Dr. Fandel to furnish to my insurance carrier all information concerning my illness or injury and authorize benefits under this claim to be made payable directly to him.

X_____
SIGN HERE