Patient Information

(complete all sections - front and back)

Patient's Name____
First Middle Initial Last

Address____
Street & Apt.# City State ZIp

Mailing Address____

Home Phone________________ Work Phone________________ Cell Phone________________

Preferred Method of Contact: ☐ Home ☐ Work ☐ Cell E-mail______________________

SS#________________ Gender ☐ Male Marital Status ☐ Single ☐Widowed

Birthdate________________ ☐ Female ☐ Married ☐ Divorced

Age________________ ☐ Other:____________

Patient's Employer ____________________ Occupation____________________

Spouse/Parent's Name ____

Home Phone________________ Work Phone________________ Cell________________

Employer________________ SS#________________ Email________________

Emergency Contact____________________**Relationship to patient**________________

Home Phone________________ Work Phone________________

How did you hear about us? (please be specific) ☐ Family/Friend____________________

☐ Verizon Phone Book ☐ Other________________ ☐ Physician____________________

☐ Website________________________ ☐ Internet________________________

Primary Health Insurance Company____________________________________

Policy #________________ Group #________________ Copay________________

Insured's Name________________________Relationship to patient____________________

Insured's Birthdate________________Insured's SSN________________Employer________________

Referral Required? ☐ No ☐ Yes

Secondary Health Insurance Company____________________________________

Policy #________________ Group #________________ Copay________________

Insured's Name________________________Relationship to patient____________________

Insured's Birthdate________________Insured's SSN________________Employer________________

Referral Required? ☐ No ☐ Yes

Chief Complaint?________________________**Onset of Problem:**____________________

Is this an injury? ☐Yes ☐No DOI:__________ Work related? ☐Yes ☐No Is this Compensation ☐Yes ☐No

Is this an auto injury? ☐Yes ☐No Attorney involved? ☐Yes ☐No Name____________________

Sign and date appropriate line
(MUST be signed if we are billing your insurance)

Insurance Signature on File

I request that payment of authorized benefits be made on my behalf to the provider for any services furnished me. I authorize any holder of medical information about me to release to the insurance companies and its agents any information needed to determine these benefits payable for related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If “other health insurance” is indicated in Item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature____Date____________________

Payment Policy

I understand that the office visit charges are payable on the day the service is rendered. I authorize Dr. Jackson and Dr. Wood to bill my insurance company. Regardless of the insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between my doctor and myself.

Signature____**Date**____________________

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

Please print and sign your name at the X’s.

I,X____, have been
(Print Name of Patient)

offered a copy of Hans Lee, M.D., Inc’s Notice of Privacy Practices. * **AVAILABLE IN THE OFFICE RECEPTION AREA**

X____ _______________
Signature of Patient/Legal Guardian Relation Date

If no patient signature above, acknowledge your efforts here and state a reason why there is no signature. You must also record this on the office notes.

____ _______________
Staff Signature Date