HARTWIG HEALTH

PATIENT INFORMATION

****PLEASE PRINT CLEARLY**** **TODAY'S DATE:**_____

PATIENT NAME:_____BIRTHDATE:_____ SEX: M / F
RACE: _____ ETHNICITY: Hispanic Not Hispanic PATIENT SS#: _____
ADDRESS:_____
(please include street address with all post office boxes)
CITY:_____ STATE:_____ ZIP:_____
HOME/CELL: ( )_____ (circle one) EMAIL: _____
MARITAL STATUS: Married Single Widow
EMPLOYER NAME: _____ WORK PHONE: ( )_____

PARENT/GUARDIAN NAME (if minor):_____ SS#:_____
PARENT PHONE: ( )_____ PARENT DOB: _____
ADDRESS:_____
CITY:_____ STATE:_____ ZIP:_____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____
HOME/CELL PHONE: _____ WORK PHONE: _____

WHO REFERRED YOU TO OUR PRACTICE? _____

(A health care proxy is someone you authorize to have access to your medical information, make appointments, obtain lab results, and communicate with our office on your behalf. Please be certain that the designated person is someone you want to be your representative.)
HEALTH CARE PROXY: _____ RELATIONSHIP: _____
HOME/CELL PHONE: _____ WORK PHONE: _____

INSURANCE INFORMATION: (Please give your insurance card to the front desk to copy)-information must be given at time of appointment in order to file this for you.

NAME OF INSURANCE:
MEDICAL:_____ NAME OF POLICYHOLDER:_____
DOB:_____ SS#_____
SECONDARY?: _____ NAME OF POLICYHOLDER:_____
DOB:_____ SS#_____

I AUTHORIZE HARTWIG HEALTH, PS. TO FILE ANY INSURANCE ON MY BEHALF AND TO PROVIDE ANY MEDICAL INFORMATION NECESSARY TO THE APPROPRIATE PERSONS FOR MY MEDICAL & FINANCIAL NEEDS:

Signature: _____ Todays Date: _____