PATIENT INFORMATION

PLEASE PRINT CLEARLY

PATIENT'S NAME _____ M F _____
First Middle Inital Last Sex Age Date of Birth

ADDRESS _____ PHONE _____

CITY _____ STATE _____ ZIP _____

ARE YOU SINGLE _____ MARRIED _____ DIVORCED _____ SEPARATED _____

SOCIAL SECURITY NUMBER _____ ARE YOU COVERED BY MEDICARE? _____

EMPLOYED BY _____ OCCUPATION _____

BUSINESS ACCESS _____ PHONE _____

CITY _____ STATE _____ ZIP _____

IF SOMEONE OTHER THAN PATIENT IS RESPONSIBLE FOR PAYMENT PLEASE COMPLETE THIS SECTION

SPOUSE OR GUARDIAN _____
First Middle Inital Last Relationship to Patient Date of Birth

ADDRESS _____ PHONE _____

CITY _____ STATE _____ ZIP _____

ARE YOU SINGLE _____ MARRIED _____ DIVORCED _____ SEPARATED _____

SOCIAL SECURITY NUMBER _____ SOCIAL SECURITY NUMBER _____

EMPLOYED BY _____ OCCUPATION _____

BUSINESS ACCESS _____ PHONE _____

CITY _____ STATE _____ ZIP _____

MEDICAL INSURANCE INFORMATION

COMPANY	GROUP OR PRIVATE	POLICY NUMBER	POLICY HOLDER
COMPANY	GROUP OR PRIVATE	POLICY NUMBER	POLICY HOLDER
COMPANY	GROUP OR PRIVATE	POLICY NUMBER	POLICY HOLDER
COMPANY	GROUP OR PRIVATE	POLICY NUMBER	POLICY HOLDER

FAMILY PHYSICIAN: _____

*** REFERRED BY: _____

NAME OF FRIEND OR RELATIVE (OTHER THAN SPOUSE) IN CASE OF EMERGENCY _____

NAME _____ PHONE _____

I hereby authorize Randall T. Weingarten, M.D. to furnish to the above insurance company(s) or to a designated attorney, all information which said insurance company(s) or attorney may request. I hereby assign to Randall T. Weingarten, M.D. all money to which I am entitled for medical and/or surgical expense relative to the service rendered by them, but not to exceed by indebtedness to said physician and/or surgeon. It is understood that any money received from the above named insurance company, over and above my indebtedness will be refund to me when my bill is paid in full. I understand I am financially resonsible to said doctor(s) for charges not covered by this assignment. I further agree in the event of non-payment, to bear the cost of collection and/or court costs and reasonable legal fees should this be required.

X _____ X _____
INSURED OR GUARDIAN SIGNATURE PATIENT'S SIGNATURE

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PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS

1. Current problems (Reason for visit).

2. When did symptoms first occur?

3. List any medications you are taking for this problem.

4. List any other medications that you take.

5. List any known allergies (includes allergies to medications).

6. Do you smoke? If so, how many packs a day?

7. List any previous surgery.

8. List any other medical problems.

9. Female Patients: Is there any possibility that you are pregnant?