PATIENT INFORMATION

Last Name: ________________________ First Name: ________________________ M.I.:

Address: __________________________ City: ______________________________ State/Zip:

Home Phone: ______________________ Cell: ______________________________ Marital Status:

Social Security #: __________________ Date of Birth: _______________________ Gender: ___________________________

Employer/Occup: __________________ Employer Phone: __________________ Email: ___________________________

Race: ____Black ____White ____Asian ____American Indian ____Native Hawaiian or Other Pacific Islander ____Other

Ethnicity: ____Hispanic/Latino ____Not Hispanic/Latino Preferred Language___________________________

EMERGENCY CONTACT INFORMATION

Name: ________________________________ Relationship: _______________________ Phone: ______________________

HEALTH INSURANCE INFORMATION - A Copy of Your Health Insurance Card(s) is Required

PRIMARY Coverage

Insurance Company: ____

Subscriber/Card Holder/Policy Owner: ____

Subscriber's Date of Birth: ____

Subscriber's Relationship to Patient: ____

SECONDARY Coverage

Insurance Company: ____

Subscriber/Card Holder/Policy Owner: ____

Subscriber's Date of Birth: ____

Subscriber's Relationship to Patient: ____

Primary Care Physician: ____ Phone: ________________________

Referring Physician: ____ Phone: ________________________

How did you hear about our office:____

Pharmacy Name: ____ Phone: ________________________

Mail Order Pharmacy: ____ Phone: ________________________

AUTHORIZATION

I hereby authorize this office to furnish information to insurance carriers including Medicare and Medicaid concerning this illness/accident and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am financially responsible for all charges whether or not covered by insurance or workers compensation. I hereby authorize photocopies of this authorization form to be valid as the original. I consent to disclosure of my medical information to outside agencies for the purpose of providing healthcare services to me. If I fail to obtain a referral, I understand that I am financially responsible. I acknowledge that I have received the mandatory information regarding " Notice of Privacy Practices." (HIPAA)

X SIGNATURE ____ **Date** ______________________

AUTHORIZATION TO RELEASE INFORMATION (Your Signature Is Required)

Do You Authorize Another Person To Receive Your Medical Information? Yes o No o

If YES, Who: ________________________________ Relationship to Patient ________________________________

Do You Authorize Another Person To Receive Your Billing Information? Yes o No o

If YES, Who: ________________________________ Relationship to Patient ________________________________

Do You Authorize Dr. Stahle or His Staff To Leave Patient Test Results on an Answering Machine or Voice Mail: Yes o No o

If YES, at which phone number(s)? ________________________________

X SIGNATURE ____ **Date** ______________________