Christopher D. Sarzen MD PC

PATIENT INFORMATION SHEET

Patient Name:_____SSN#_____

Address:_____
STREET CITY STATE ZIPCODE

Date of Birth: _____ **Gender** (please circle): M F **Status:** Married Single Divorced Widowed

Home Phone #: _____Cell Phone #:_____Work Phone #:_____Employer:_____
Work Address:_____

Emergency Contact (Name/Telephone #):_____

Primary Care Physician (First/Last Name):_____

Referring Physician (First/Last Name):_____

I authorize the physician or anyone acting on his/her behalf to leave pertinent messages for me regarding my medical condition on my answering machine and/or voice mail.
(Please circle one) Yes No

Financially Responsible Party *(If Different From Patient)*

Last Name:_____ First Name:_____ MI:_____

Street Address:_____City:_____ State:_____

Home Phone:_____Work Phone:_____ SS#_____

Date of Birth:

Relationship to Patient: Gender: M F

Insurance Information *(Must be completely Filled Out)*

Primary Insurance Co Name:	**Secondary Insurance Co Name:**
Insurance Co Address:	Insurance Co Address:
Patient's Insurance Policy #:	Patient's Insurance Policy #:
Patient's Group #:	Patient's Group #:
Insured's Name:	**Insured's Name:**
Insured's SS#:	**Insured's SS#:**
Insured's Date of Birth:	**Insured's Date of Birth:**
Insured's Employer Name:	Insured's Employer Name:
Insured's Employer Phone #:	Insured's Employer Phone #:
Patient's Relationship to Insured:	Patient's Relationship to Insured:

The signature below is my authorization for the release of information necessary to my primary care, referring physician's office, and/or consultants if needed, and as necessary to process insurance claims, obtain pre-authorizations or pre-certifications for treatment, process insurance applications, and obtain prescriptions. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for a Medicare claim . I hereby authorize payment directly to Christopher D. Sarzen MD PC for any surgical and/or medical benefits available to me under my insurance policy for these services. I also understand that I am responsible for payment in full for services rendered. I permit a copy of this authorization to used in place of the original. For Medicare, I understand it is mandantory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.) Regulations pertaining to Medicare assignment of benefits also apply.

Signature:_____ Today's Date:_____

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