Robert M. Stiegel M.D., LTD PLEASE PRINT DATE: ____________

PATIENT INFORMATION

First Name: ______________________ MI: _____ Last Name: ______________________________

Birth Date: ____________ Age: _____ Gender (circle one): M / F Social Security #: ______________

Address: ____ Contact #s: Home: ______________
Street

____ Cell: ______________
City State Zip

Marital Status (check one): __ Single __Married __Widow __Divorced __Separate E-mail: ______________

Employer/ School: ____________________________________ Student?: No Yes- If yes: FT/Part time

Employer Address: ____ Contact#: ______________
Street City State Zip

Referring Physician: ______________________ **Primary Care Physician**: ______________________

EMERGENCY CONTACT: Name/Relationship ____________________________ Contact#: ______________

Pharmacy: ____________________________ Phone#/location: ____________________________

Spouse, Parent or Guardian Information (If under 18, name of parent with whom you reside)

First Name: ______________________ MI: ______ Last Name: ______________________________

Birth Date: ____________ SS#: __________________ Relationship: Spouse Parent Other

Address: ____
Street City State Zip

Contact numbers: Home: ______________ Cell: ______________ E-mail: ______________

Employer Address: ____ Contact#: ______________

INSURANCE INFORMATION: *****PLEASE HAVE CARDS READY FOR STAFF TO COPY*****

PRIMARY: ______________________________________ POLICY#: ______________________

SUBSCRIBER's NAME: ____________________________ BIRTH DATE: __________ GROUP #: __________

Holder's Relationship to patient: __ Self __ Spouse __ Parent __ Other (specify) ______________

SECONDARY: ______________________________________ POLICY#: ______________________

SUBSCRIBER'S NAME: ____________________________ BIRTH DATE: __________ GROUP #: __________

Holder's Relationship to patient: __ Self __ Spouse __ Parent __ Other (specify) ______________

I understand it is my responsibility to furnish the correct insurance information. I hereby assign all medical and/or surgical benefits to which I am entitled, including Medicare, private insurance, and other health plans to **Robert M. Stiegel, MD, LTD**. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signed: ____ Date: ______________
Patient or Responsible Party