Steven F. Harwin, MD, FACS

GENERAL INFORMATION: (PLEASE PRINT and CIRCLE AS NEEDED) **Date of Visit**_____

Name: First_____ MI_____ Last_____ Sex: M F AKA Names_____

Language: English Spanish Other:_____ Race: American Black Other:_____ Ethnicity: Hispanic Non-Hispanic Veteran: Yes No

Soc. Sec.# _____ Email:_____ Date of Birth_____ Age_____

Address_____ City/State_____

Apt _____ Zip_____ **Tel:** Home_____ Work_____ Cell_____

Employer_____ Occupation _____ Working Now? Yes No

Marital Status: M D S W P Emergency Contact (Relationship) _____ Tel:_____

Referred By Dr._____ Office Patient:_____ Web Ins. Plan

Primary Care Physician_____ **My Co-Payment is**: $ _____

Doctor's Address_____ Tel:_____

Primary Ins. Co. for Doctors' Services_____ Tel:_____

Address for Provider Claims:_____

Name of Insured_____ Date of Birth_____

SS# _____ ID/Policy# _____ Group _____

Primary Hospital Insurance (if different from above) _____

Secondary Company for Doctors' Services _____

Address/Telephone_____

Name of Insured_____ Date of Birth_____

SS# _____ ID/Policy# _____ Group _____

***Important:* If a referral is needed, your insurance company will not allow you to be seen without it. If you did not bring it, your visit must be re-scheduled. We cannot get it for you on the day of your visit.**

Compensation or ***No Fault Cases:*** If your problem is a **documented and valid** open case, your regular insurance company ***will not pay*** for your care, so you must answer the next two questions carefully and accurately before the doctor sees you today. ***Remember, your answers cannot be changed after this visit!***

- Is your problem a result of a documented open Workers' Compensation Claim? Yes No Initials _____
- Is your problem a result of a documented open No Fault Auto Accident? Yes No Initials _____

If either answer is YES, you must have the following information with you to be seen today:

Date of Accident _____ Location_____ Is the case is now open? Yes No

Insured/Employer_____ Tel: _____

Address_____ Carrier#_____

Insurance Company_____Policy#_____File#_____

Address_____ Tel_____

I hereby assign, transfer and set over to Dr. Steven F. Harwin and his assistants, sufficient monies and/or benefits to which I may be entitled from governmental agencies, insurance carriers or others, who are financially responsible and liable for my medical care and hospitalization, to pay for care and treatment rendered to me or my dependent. I recognize that I am responsible for any insurance deductible not met, and all non-covered or denied claims and services, at the usual and customary fee schedule. I authorize the release of any medical or other information necessary to process these claims. (5-17)

Patient Signature _____ **Date** _____