PATIENT INFORMATION

Name _____
Last Name First Name Middle Name Maiden Name

Address_____
Street Apt. No. City State Zip Code

Home Phone_____ Cell Phone_____Email_____

Date of Birth _____ Age _____ Marital Status ☐S ☐M ☐W ☐D SS# _____

Employed By _____ Occupation _____ Work Phone_____

Address _____
Street Suite No. City State Zip Code

Spouse/Parent's Name _____ Occupation_____

Spouse/Parent's Employer _____Spouse/Parent's Work Phone _____

IN CASE OF EMERGENCY: Contact _____Home Phone # _____

Relationship to Patient_____Work Phone # _____

IN CASE OF JOB RELATED INJURY:

Employer Contact Person: _____Phone Number_____

INSURANCE INFORMATION

Do you have insurance to cover the fees for services rendered? ☐ Yes ☐ No

PRIMARY INSURANCE	SECONDARY INSURANCE
Name of Insured	Name of Insured
Primary Insurance	Secondary Insurance
Insurance Address	Insurance Address
ID #	ID #
Group #	Group #
Insured's Date of Birth	Insured's Date of Birth

AUTHORIZED PERSON'S SIGNATURE

I , undersigned, assign directly to Jean-Claude Hage, M.D. all Medical and/or Surgical benefits, if any, otherwise payable to me for services rendered.
I understand that I am financially responsible for all charges, whether or not paid by insurance.
I hereby authorize Jean-Claude Hage, M.D. to release all information necessary to secure payment on benefits

Signature Date