PATIENT INFORMATION

# Luann K. Hassan, M.D., P.A.

Acct.#
Date Mailed:
Ref. Doctor:
Date Received:

| **Patient's Information:** | | | | | |
|---|---|---|---|---|---|
| Last: First: | | M.I.: | Sex: | DOB: | Age: |
| Address: | | City: | | State: | Zip: |
| Home Phone: ( ) | SS# - - | Occupation: | | | |
| Employer: | | Work Phone: ( ) | | | |
| Employer's Address: | | City | | State: | Zip: |

| **Patient's Insurance:** | | Primary Physician's Name: | |
|---|---|---|---|
| If Pre-Certification is required or PCP referral, please provide phone number: | | | |
| Insurance Carrier: | | | |
| Claims Address: | | City: | State: Zip: |
| Insured's Name: | | Relationship: | |
| Policy: | Group: | Plan: | |
| Subscriber: | Certificate: | Control: | |

| **Husband / Father Information:** | | | | | |
|---|---|---|---|---|---|
| Last: First: | | M.I.: | Sex: | DOB: | Age: |
| Home Phone: ( ) | SS# - - | Occupation: | | | |
| Employer: | | Work Phone: ( ) | | | |
| **Insurance** (if different) | | | | | |
| Claims Address: | | City: | | State: | Zip: |
| Policy: | Group: | Plan: | | | |
| Subscriber: | Certificate: | Control: | | | |

| **Nearest Relative Not Living With You:** | | | |
|---|---|---|---|
| Last: First: | Relation: | Phone: ( ) | |
| Address: | City: | State: | Zip: |

- *All services rendered by Luann K. Hassan, M.D., P.A. are charged directly to the patient. We are happy to file all insurance forms at no charge to the patient, and credit the patient account with any insurance payment made. Unless we are contracted with your insurance company to accept what they approve, your deductible or percent not covered by the insurance company is due within 30 days of notice. If you do not have insurance you must make arrangements for paying at the time of service. Your signature below indicates you understand that payment of charges incurred by yourself are ultimately your responsibility and you agree to comply with this policy.*

- I hereby authorize Luann K. Hassan, M.D., P.A. to furnish my records concerning my illness or treatment to other physicians or insurance carriers:

Your signature: _____ Date: _____