

PATIENT INFORMATION SHEET

Name of Patient _____ Sex: Male _____ Female _____

Date of Birth _____ Age _____ Social Security Number _____

Residential Address _____ Marital Status _____

Mailing Address (if different) _____ Home Phone _____

Employer _____ Occupation _____ Cell Phone _____

Employer's Address _____ Work Phone _____

Name of Spouse (or Parent of Minor) _____ Date of Birth _____

Address _____ Home Phone _____

Employer of Spouse (or Parent of Minor) _____ Occupation _____

Social Security Number of Spouse (or Parent of Minor) _____

EMERGENCY OR AFTER HOURS CONTACT

Name _____ Relationship _____

Address _____ Phone _____

Internist or Family Doctor _____ Who referred you to this office? _____

Your Insurance Companies (including Medicare/Medi-cal) _____

*****(Cash Patients: Full payment is required at time of visit for all services rendered)*****

I agree to pay for all services rendered to me or to the patient named above. I understand that my insurance company is not responsible for my account although a claim may be pending. I authorize release of any information necessary to settle my account or to process insurance claims. I agree to remit any collection or legal fees in the event of a defaulted account. I agree that a photocopy of this authorization shall be as valid as the original.

Date _____ Patient _____
(or Responsible Party For Patient)

I hereby certify that I have provided all current insurance information. I also agree that I have obtained any necessary authorization or referral required by my insurance. I understand that I may be fully responsible for any charges related to services rendered if I choose to be seen without the required authorization.

Date _____ Patient _____

MEDICARE PATIENTS PLEASE SIGN EXTENDED AUTHORIZATION FORM BELOW:

**STATEMENT TO PERMIT PAYMENT OF MEDICARE
BENEFITS TO SUPPLIER, PHYSICIAN, OR PATIENT**

Name of Beneficiary

Health Insurance Claim Number

I request that payment of authorized Medicare benefits be made either to me or on my behalf to J. Terence Daly, M.D., Anne Hanneken, M.D., or Robyn Cohen, M.D. for any services rendered to me by Dr. Daly, Dr. Hanneken, or Dr. Cohen. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Date

Signature of Patient

PATIENTS WITH PRIVATE OR SUPPLEMENTAL INSURANCE, PLEASE COMPLETE AUTHORIZATION BELOW:

AUTHORIZATION FOR PAYMENT AND ASSIGNMENT OF BENEFITS

I authorize and direct my Insurance Company _____
to pay all medical and surgical bills incurred on behalf of _____
(name of patient)

to J. TERENCE DALY, M.D., ANNE HANNEKEN, M.D., or ROBYN COHEN, M.D. I understand that I am responsible for any charges not covered by this assignment. The above named insurance company is also authorized to release information regarding my coverage and status of my claims to J. TERENCE DALY, M.D., ANNE HANNEKEN, M.D., or ROBYN COHEN, M.D. I authorize release of financial information relevant to collection in the event of a defaulted account. A copy of this form shall be considered valid.

Date

Patient/Responsible Party