PATIENT BIOGRAPHICAL FORM

Patient Name: _____ (Last / First / MI) Date of Birth:* _____

Social Security No: _____ Race:* _____ Gender:* M F (Circle One)

Ethnicity:* _____ Preferred Language:* _____ Age: _____

Address: _____ (Street / City / State / Zip)

Secondary Address: _____ (Street / City / State / Zip)

Phone Numbers: _____ Marital Status: S M D W (Circle One)

Email Address: _____ Pharmacy: _____

Spouse's Name: _____ Pharmacy Phone: _____

Mobile Phone: _____ Work Phone: _____

Employer: _____ Title/Job: _____

Primary Care Doctor: _____ Phone: _____

Emergency Contact: _____ Phone: _____

I hereby acknowledge that I have received the Kagan, Jugan & Associates Medical Information Privacy Notice for my review prior to receiving services. May we leave a message on voicemail/answering machine? _____

Besides myself, I give you permission to leave a detailed message with: _____ (Name)

_____ DATE _____ SIGNATURE

I hereby authorize and consent to treatment by Kagan, Jugan & Associates, P.A. as deemed reasonable and necessary by the physician at the time of my visit.

_____ DATE _____ SIGNATURE

ASSIGNMENT OF INSURANCE RIGHTS AND BENEFITS

I hereby assign all medical and/or surgical benefits to which I am entitled to Kagan, Jugan & Associates, P.A.and further assign to Kagan, Jugan & Associates, P.A. the right to bring a cause of action against the insurer to recover such benefits. A copy or fax of this assignment is as valid as the original.

_____ DATE _____ SIGNATURE

* Items Required for Electronic Medical Records Meaningful Use Guidelines Required by the US Government

INSURANCE INFORMATION

Patient name: _____ Date: _____

Is your visit related to a motor vehicle injury? YES NO (Circle One) Date of Injury: _____

Is your visit related to an on-the-job injury? YES NO (Circle One) Date of Injury: _____

Are you represented by an attorney? YES NO (Circle One) Attorney Name: _____

Phone: _____

PRIMARY INSURANCE COVERAGE

Name of Company: _____

Address: _____
Street City State Zip

ID Number: _____ Group Number: _____

SECONDARY INSURANCE COVERAGE

Name of Company: _____

Address: _____
Street City State Zip

ID Number: _____ Group Number: _____

OTHER INSURANCE COVERAGE (Auto/Worker's Comp)

Name of Company: _____

Address: _____
Street City State Zip

Phone No: _____ Policy No: _____ Group No: _____

Insured Name: _____ Relationship to Patient: _____
Last First MI

Insured SSN: _____ Insured DOB: _____

Claim Number: _____

Adjustor: _____ Phone: _____

Case Manager: _____ Phone: _____