

Patient account# _____

STEPHEN P. HARDY M.D.

Patient Name _____ Birthdate _____ Age _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work _____ Cell _____

E-mail Address _____

Soc.Sec.# _____ - _____ - _____ Marital Status _____ Sex Male Female

Occupation _____ Employer _____

In Case of Emergency Please Contact _____ Phone _____

Referred by _____ Phone _____

PARENT/GUARDIAN INFORMATION IF PATIENT IS MINOR

Father/Guardian Name _____

Address(if different from patient's) _____

City _____ State _____ Zip _____

Home Phone _____

Mother/Guardian Name _____

Address(if different from patient's) _____

City _____ State _____ Zip _____

Home Phone _____

HEALTH INSURANCE INFORMATION

Primary Insurance _____

Insured Name _____ Soc.Sec.# _____

Birthdate _____ Policy ID# _____

Secondary Insurance _____

Insured Name _____ Soc.Sec.# _____

Birthdate _____ Policy ID# _____

ACCIDENT INFORMATION

Date of Accident _____ Worker's Comp Auto Accident Other _____

Insurance Carrier _____ Phone _____

Address _____ City _____ State _____ Zip _____

Claim or Policy # _____ Name of Adjustor _____

ASSIGNMENT AND RELEASE OF INFORMATION

NOTE: Insurance Pre-Authorization: It is the responsibility of the patient to notify this office if your insurance requires this for any services. Assignment and Release of Information: I hereby authorize Dr. Hardy to release any information acquired in the course of my examination and treatment to the insurance company. I also authorize payment directly to the physician . **By signing below I recognize and accept responsibility for any balance remaining after payment of benefits.**

Signature _____ **Date** _____