George A. Haddad, MD

PLEASE PRINT

_____/_____/_____
FIRST NAME MI LAST NAME BIRTHDATE

_____
ADDRESS CITY STATE ZIP CODE

(_____)_____(_____)_____ _____-_____-_____ _____
HOME PHONE CELL PHONE SOC SEC NUMBER RACE

_____ _____ M____F____
ETHNICITY LANGUAGE SPOKEN SEX

WHAT IS YOUR E-MAIL ADDRESS?_____

Pharmacy name_____**Pharmacy Phone #** _____

_____(____)_____EXT_____
YOUR EMPLOYER WORK PHONE

_____
EMPLOYER ADDRESS CITY STATE ZIP CODE

_____(_____)_____ _____
EMERGENCY CONTACT NAME PHONE RELATIONSHIP

_____(_____)_____ _____
EMERGENCY CONTACT NAME PHONE RELATIONSHIP

_____
PRIMARY INSURANCE COMPANY NAME POLICY/ID NUMBER GROUP NUMBER

_____/____/_____
POLICYHOLDER NAME BIRTHDATE POLICYHOLDER EMPLOYER

_____
POLICYHOLDER ADDRESS (IF DIFFERENT FROM ABOVE) CITY STATE ZIP CODE

_____
SECONDARY INSURANCE COMPANY NAME POLICY/ID NUMBER GROUP NUMBER

_____/_____/_____
POLICYHOLDER NAME BIRTHDATE POLICYHOLDER EMPLOYER

_____
POLICYHOLDER ADDRESS (IF DIFFERENT FROM ABOVE) CITY STATE ZIP CODE

PLEASE BE SURE YOU HAVE NOTIFIED YOUR INSURANCE COMPANY THAT WE ARE YOUR PRIMARY PHYSICIAN BEFORE YOUR APPOINTMENT.

I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS AND I AUTHORIZE THE PAYMENT OF ALL MEDICAL BENEFITS FROM MY INSURANCE COMPANY(S) DIRECTLY TO **George A. Haddad, MD.** UNDERSTAND THAT IF FOR ANY REASON MY INSURANCE IS INVALID OR NOT GIVEN FOR ANY SERVICE, I WILL BE RESPONSIBEL FOR THE FULL CHARGES INCURRED DURING MY VISITS. I ALSO UNDERSTAND THAT I AM RESPONSIBLE FOR ANY CHARGES NOT COVERED BY MY INSURANCE SUCH AS COPAYS, DEDUCTIBLES AND COINSURANCE.

SIGNATURE_____DATE_____

*******YOU MUST BRING YOUR INSURANCE CARD/CARDS AND PHOTO ID TO YOUR APPOINTMENT*****