Miles Hassell MD
Internal Medicine
Comprehensive Risk Reduction Clinic
goodfoodgreatmedicine.com

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PATIENT INFORMATION

- Welcome to the office - *please print*

Last Name:	First Name:	MI:	Preferred Name:
Street Address:			
City:	State:	Zip Code:	
Phone (home): ( ) -	Phone (work): ( ) -	Phone (cell): ( ) -	
Sex: ☐ Female ☐ Male	E-mail Address: ☐ *check here to add your e-mail to our newsletter list*		
Marital Status: ☐ Single ☐ Widowed ☐ Divorced ☐ Married (spouse's name):	SSN: - -	Birth Date: - -	
	Employer's Name:		
Referred By: *Name*	Occupation:		

EMERGENCY CONTACT(S)

Emergency Contact Name: *Primary*		Relationship:
Phone (home): ( ) -	Phone (work): ( ) -	Phone (cell): ( ) -
Emergency Contact Name: *Secondary*		Relationship:
Phone (home): ( ) -	Phone (work): ( ) -	Phone (cell): ( ) -

INSURANCE INFORMATION

Enrolled in Medicare: ☐ No ☐ Yes (please complete a *Patient-Physician Medicare Opt Out Contract*)
Primary Insurance: *Company, Address, Phone Number, Effective Date, Group #, ID #*
Secondary Insurance: *Company, Address, Phone Number, Effective Date, Group #, ID#*

INSURANCE AUTHORIZATION and ASSIGNMENT

I request payment of authorized insurance company benefits to be made payable to Miles Hassell, M.D. for any services furnished to myself by said physician(s). I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agent any information needed to determine these benefits or the benefits payable to related services.
I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown.

Signature:	Date: