Danny Hernandez MD, CIME

NEW PATIENT INFORMATION SHEET

Please print clearly. Please complete all information so that your claim can be processed quickly and efficiently. Thank you!

PATIENT INFORMATION

Name: (Last) _____ (First) _____ (MI) _____

Date of Birth: _____/_____/_____ **Social Security#**: _____-_____-_____ **Sex**: _____Male _____Female

Marital Status: S M W D

Address: _____**City**: _____ **State**: ____ **Zip**: _____

Phone#: (___) _____-_____ **Cell#**: (___) _____-_____ **Work#**: (___) _____-_____

Email Address: _____

Employer Name: _____

Employer Address: _____**City**: _____ **State**: _____ **Zip**: _____

Phone#: (_____) _____-_____ **Fax#**: (_____) _____-_____ **Full Time** _____**Part Time**_____

If Student, School Name: _____

WORKER'S COMP/ ACCIDENT INFORMATION

Insurance Name: _____

Address: _____**City**: _____ **State**: ____ **Zip**: _____

Adjuster Name: _____ **Adjuster Phone#**: (_____) _____-_____

Date of Injury or Accident: _____/_____/_____ **Claim#**: _____

Type of Injury› • • • • • • • †• • • • • • • • • • • • • • • • †• • • †• • • • • • • • • • • • • • • • •

Place of work during time of accident: _____ **Phone#**: (___) _____-_____

INSURANCE INFORMATION

Insurance Co.: _____ **Phone#**: (___) _____-_____

Insurance Address: _____**City**: _____ **State**: _____ **Zip**: _____

Identification ID#: _____ **Group ID#**: _____

Insured Name: _____**Relationship to Patient**: ____ Self ____ Spouse ____Dependent

Insured's Name: _____ **Phone#**: (___) _____-_____

Employer Address: _____**City**: _____ **State**: _____ **Zip**: _____

Insured Date of Birth: _____/_____/_____ **Social Security#**: _____-_____-_____ **Sex**: ____Male ____Female

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NEW PATIENT INFORMATION SHEET

INSURANCE INFORMATION #2

Insurance Co.: _____ **Phone#**: (___) _____-_____

Insurance Address: _____**City**: _____ **State**: _____ **Zip**: _____

Identification ID#: _____ **Group ID#**: _____

Insured Name: _____**Relationship to Patient**: ____ Self ____ Spouse ____Dependent

Insured's Name: _____ **Phone#**: (___) _____-_____

Employer Address: _____**City**: _____ **State**: _____ **Zip**: _____

Insured Date of Birth: _____/_____/_____ **Social Security#**: _____-_____-_____ **Sex**: ____Male ____Female

Emergency Information

Name of person _____

Phone#: (___) _____-_____

Relationship: _____

Can we contact person in case of emergency with patient? _____

In case we cannot get a hold of patient due to abnormal test results, can we contact above person? _____

*I hereby assign, transfer, and set over to DWH Medical Center for pain control all my rights, title, and interest to my medical reimbursement benefits **under my Insurance policy**. This authorization shall remain valid until written notice is giving by me revoking said authorization.*

I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Print Name: _____ **Date**: _____/_____/_____

Patient's Signature: _____

OFFICE USE ONLY

Accepted Area of Injury: _____Amt. of Medical Benefits: _____

In Litigation› • • • • No