Hawthorne Medical Associates
HMA Entered by________________
PATIENT INFORMATION FORM
Acct #: ____________________

Patient Name:			Social Security Number:		Sex: M F
MAILING Address:			Date of Birth:		Age:
City:	State:	Zip:	Marital Status: **S**ingle **M**arried **W**idowed **D**ivorced **Sep**arated		
Street Address, if different: City, State, Zip			Who referred you to our practice? Name: ____________ Phone Book Insurance Plan Other ____________		
Home Phone:	Cell Phone:				
Beeper:	E-Mail Address:				
Employer: Full Time Part Time			Retired? No Yes	Date of Retirement:	
City:	State:	Zip:	In School? No Full Time Part Time	Name of School:	
Work Phone:	Occupation:		Disabled? No Yes Reason:		
Spouse or Emergency Contact Name:			Relation to Patient: Spouse Son/Daughter Parent Friend Other ________		
Street Address:			Social Security #:	Date of Birth:	
City:	State:	Zip:	Home Phone:	Work Phone:	Cell Phone:

PRIMARY INSURANCE: (We will need to copy your insurance cards)

Insurance Company: ______________________________ Type: PPO HMO POS
Name of Insured: __________________________ DOB: ____________ SSN: ________________
Relation to Patient: Self Spouse Parent Other ________________
Insured's Employer: __________________________ Effective Date: ______________________

SECONDARY INSURANCE:

Insurance Company: ______________________________ Type: PPO HMO POS
Name of Insured: __________________________ DOB: ____________ SSN: ________________
Relation to Patient: Spouse Parent Other ________________
Insured's Employer: _____________________________ Effective Date: __________________

AUTHORIZATIONS, MEDICAL RECORDS RELEASE, ASSIGNMENT OF BENEFITS:

1. Treatment Authorization: I authorized you to give me reasonable and proper medical care by today's standards.
2. Release of Information: I authorize release of my medical records to Hawthorne Medical Associates, and from Hawthorne Medical Associates to other healthcare providers, including human immunodeficiency virus, psychiatric, drug/alcohol abuse records, venereal disease and any other statutory protected diseases, as necessary for continued medical care, to obtain insurance reimbursement, or to comply with utilization review. I authorize this office to obtain previous medical records from other physicians and/or medical facilities including human immunodeficiency virus, psychiatric, drug/alcohol abuse records, venereal disease and any other statutory protected diseases. A faxed copy of this authorization can serve as an original.
3. Medicare Lifetime Signature on File (if applicable): I request that payment of authorized Medicare benefits be made to Hawthorne Medical Associates for any services furnished me by a member of this group. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services any information needed to determine these benefits or benefits payable for related services.
4. Assignment of Benefits: I request that payment of authorized insurance benefits be made on my behalf to Hawthorne Medical Associates for any services furnished to me.
5. Financial Responsibility: I understand that Hawthorne Medical Associates will file my insurance as a courtesy to me, and that I remain responsible for payment of copays, coinsurance, deductibles, non-covered services and any other charges not paid by insurance within 45 days.

2010 Signature: ______________________________ Date: __________________________