

ALLAN K. BERNSTEIN, DDS

PATIENT INFORMATION SHEET

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State & Zip: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Marital Status:  Married  Single  Other

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  Male  Female

Guardian's Name (if minor) \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Drivers License Number \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Name of Spouse: \_\_\_\_\_ Spouse's Date of Birth: \_\_\_\_\_

Spouse's Social Security Number: \_\_\_\_\_ Employer: \_\_\_\_\_

Please list the names of two people we may contact in case of emergency:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Address of Primary Care Physician: \_\_\_\_\_

Date of last physical exam: \_\_\_\_\_ Referred by: \_\_\_\_\_ Phone: \_\_\_\_\_

**I UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME, AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS, HOWEVER, I AM RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE COVERAGE.**

**I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE OR OTHER INSURANCE COMPANY BENEFITS BE PAID ON MY BEHALF TO THIS OFFICE FOR ANY SERVICES PROVIDED BY THIS PHYSICIAN. I UNDERSTAND MY SIGNATURE REQUESTS PAYMENT BE MADE AND AUTHORIZES RELEASE OF MEDICAL INFORMATION NECESSARY TO PAY THE CLAIM. IF ITEM 9 OF HCFA-1500 IS COMPLETED, MY SIGNATURE AUTHORIZES RELEASING THE INFORMATION TO THE INSURER OR AGENCY SHOWN.**

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_