

PLEASE PRINT

Last Name: _____	First: _____	M.I.: _____
Address: _____	City: _____	State: _____ Zip: _____
Home Phone: _____	Cell Phone: _____	Work Phone: _____ Leave Message: Y ___ N ___
Date Of Birth: _____	Age: _____	Social Security: _____ Email Address: _____
Sex: _____	Marital Status: _____	Spouse's Name: _____
Primary Care Physician: _____	Referral Physician/Friend: _____	
Employer's Name: _____	Employer's Phone: _____	
Occupation: _____	Spouse's Occupation: _____	
Person Responsible For Payment: _____	Relationship to Patient: _____	
Name of Parents or Guardians and Address If Under Age 18: _____		
Friend Or Relative Not Living With Patient: _____	Phone: _____	
Referral Source: Insurance Directory/Web ___; Yellow Pages – Embarq – Bell South – Sprint; Web Search – Google – Yahoo Orlando Magazine – Hunters Creek Lifestyle – Central FL Lifestyle – SW Orlando Bulletin; Other _____		

METHOD OF PAYMENT: CASH _____ CHECK _____ CHARGE _____

If visit is due to an accident of any kind please give date of the accident

Primary Carrier Name: _____

Insured's Name: _____

Insured's Date Of Birth : _____ Relationship To The Patient: _____

Policy Number: _____ Phone Number: _____

Secondary Carrier Name: _____

Insured's Name: _____

Insured's Date Of Birth : _____ Relationship To The Patient: _____

Policy Number: _____ Phone Number: _____

Authorization for the release of information and assignment to pay insurance benefits.

I hereby authorize Wade W. Han, M.D., P.A. to release to the above named Insurer such information as may be necessary for the completion of my insurance claim; and further, I authorize and direct the named Insurer to pay directly to Wade W. Han, M.D., P.A. any and all benefits up to the amount of my bill accruing to me in connection with all medical treatment in the office and any confinement in the hospital. I understand I am financially responsible to the Wade W. Han, M.D., P.A. for charges not covered by this authorization.

Signature: _____ **Date:** _____