MICHAEL J. HAWES, M.D.
Confidential Patient Information

Patient Name_____Date_____
Last First Middle

Address_____
Street Apt.# City State Zip Code

Home Phone_____Social Security #_____

Date of Birth_____Age_____Sex_____Marital Status_____

Occupation_____Employer_____
(Of responsible parent if patient is minor)

Employer's Address_____Business phone_____
Street City State Zip Code

Spouse's or Parent's Name_____Phone_____

Spouse's or Parent's Employer_____Phone_____

Nearest Relative (not living with you)_____Relationship_____

Address of Relative_____Phone_____
Street City State Zip Code

Referred by _____Primary Physician_____

INSURANCE If insurance is group insurance-list company name_____

Primary Insurance_____
Name of Insurance Policy # Group # Subscriber name

Secondary Insurance_____
Name of Insurance Policy # Group # Subscriber name

RESPONSIBLE PARTY INFORMATION: Complete the section below only if someone other than the patient is responsible for the bill.

Name of Responsible Party_____Daytime Phone#: _____

Relationship_____Address (if different than patient)_____

Reason for seeing Dr. Hawes? _____

ASSIGNMENT OF BENEFITS & RELEASE OF MEDICAL INFORMATION

I authorize the release of any medical information necessary to process my claim(s) for services rendered. I authorize payment of medical benefits to Michael J. Hawes, P.C. for the services rendered. (A copy is as valid as the original.)

_____ _____
Signature Date