

Steven A. Chismar, MD, FACOG

**PATIENT MAINTENANCE, ASSIGNMENT OF BENEFITS &
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

Personal Information

Name: First _____ Middle Initial ____ Last Name _____

SSN: _____ - _____ - _____ DOB: ____/____/____ Marital Status: M S D W(circle one)

Race/Ethnicity: _____ Latino/Hispanic: Y N

Street: _____ Apt: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (____) _____ Cell Phone: (____) _____

Work: (____) _____ Employer _____ City _____

Email: _____

Emergency Contact: _____

Phone: (____) _____ Relationship: _____

Referred by _____ Medical Doctor: _____

Preferred Drug Store _____ City _____

Insurance Information Complete if insured through spouse or family member (subscriber)

Subscriber: _____ Relationship _____

Subscriber Address Street _____ Apt: _____

City: _____ State: _____ Zip Code: _____

Subscriber DOB: ____/____/____ Subscriber SSN: _____ - _____ - _____

Home phone: (____) _____ Work : (____) _____

Subscriber Employer _____ City _____

ASSIGNMENT OF BENEFITS: I hereby assign all medical and/or surgical benefits to which I am entitled including Medicaid, Medicare, private insurance and other health plans to Dr. Steven A. Chismar. This agreement will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize assignee to release all information necessary to secure payment.

Patient Signature: _____ Date: _____

I have received a copy of Steven A. Chismar, M.D.'s Notice of Privacy Practices and After Hours Communication Privacy Notice.

Patient Signature: _____ Date: _____