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 _____

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 while filing insurance claims is a courtesy extended to all our patients, I am financially responsible for all charges whether or not paid by said insurance from the date the services are rendered. 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: _____