# BRIAN G. SHERMAN, M.D.

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## PATIENT INFORMATION SHEET

DATE: _____ BY WHOM WERE YOU REFERED: _____

PATIENT: _____ SEX: ____ AGE: _____
LAST FIRST M.I.

DOB: _____ HOME PHONE: (____)_____CELL #(____)_____

ADDRESS: _____
STREET CITY STATE ZIP CODE

Email Address : _____ Primary Care Doctor_____

Employer
/ School: _____ _____
**NAME** **PHONE**

MARITAL STATUS: SINGLE___ MARRIED___ SEPARATED___ DIVORCED___ WIDOWED ___

Spouse or Guardian Name: _____ Cell#(_____)_____

NEAREST RELATIVE: _____PHONE: (___)_____
(NOT LIVING WITH PATIENT)

**For a Minor**: Child resides with: Mother ____ Father _____ Both _____

Mother Name: _____ Address: _____

Father Name: _____ Address: _____

### … INSURANCE INFORMATION …

PRIMARY INSURANCE COMPANY: _____

Policy Holder: _____Date of Birth _____

Policy Number: _____ Group Number: _____

Secondary Insurance Company_____

Policy Holder: _____Date of Birth_____

Policy Number: _____ Group Number: _____

**PLEASE PRESENT INSURANCE CARD(S) TO THE RECEPTIONIST**

I UNDERSTAND AND AUTHORIZE THE FOLLOWING:

1. Payment at the time of service is requested unless other arrangements have been made.
2. Medical and/or demographic information may be released to my insurance carriers for the purpose of filing this or any future medical claim.
3. Medical insurance benefits will be assigned and paid directly to Brian G. Sherman, M.D.
4. I am required to pay any charges incurred which are not paid by my insurance or third party payers.

I also authorize Brian G. Sherman, M.D. to provide medical information to medical providers I have been referred by or may be subsequently referred to. I understand that this information may be transmitted via fax machine to expedite continuity of care.

_____ _____

Signature of Patient / Legal Representative Date

I request that payment of authorized Medicare/Other insurance company benefits be made either to me or on my behalf to Brian G. Sherman, M.D. for any services furnished me by the party/physician who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.) Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier or any other insurance company any information needed for this or a related Medicare/Other insurance company or a related Medigap claim. I permit a copy of this authorization to be used in place of the original.

_____ _____

Signature Date

**For Minor**

Agreement for examination and treatment, and for possible future examination and treatment even if patient is unaccompanied by parent or guardian.

_____ _____

Signature Date