WILLIAM J. LITTMAN, M.D., P.C.

Internal Medicine and Cardiology

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Name _____
Last First Middle

Birth Date _____ Age _____ Sex: M F

Social Security # _____ Marital Status: Married Single Widowed Divorced Minor

Home Address _____
Street

_____
City & State Zip Code Home Phone

Employer _____ Occupation _____

Work Address _____ Phone _____

Person to Notify in Case of Emergency: _____ Relationship to Patient _____

Phone # _____ Address _____

Referred by: _____

RESPONSIBLE PARTY INFORMATION (If other than patient)

Responsible Party Name _____ Relationship to Patient _____

Address _____ Phone # _____

Employer _____ Work Phone # _____

Employer Address _____

MEDICAL INSURANCE INFORMATION

Insurance Policy #1 (Primary) Insurance Company Name _____

Address _____

Name of Insured _____ Social Security # _____ Date of Birth: _____

Relationship to Patient: _____ Employer Name / Address: _____

Group # _____ Policy # _____ Employer Phone: _____

Insurance Policy #2 (Secondary) Insurance Company Name _____

Address _____

Name of Insured _____ Social Security # _____ Date of Birth: _____

Relationship to Patient: _____ Employer Name / Address: _____

Group # _____ Policy # _____ Employer Phone: _____

COMPLETE IF YOUR VISIT IS DUE TO A JOB RELATED INJURY

Date of Injury _____ How Injury Occurred _____

Name of Employer _____ Phone # _____

Employer Address _____

Person's Name & Number to verify work injury: _____

Company's Insurance Carrier _____

Was claim filed with your employer? Yes No

PRESENT MEDICATION _____

ALLERGY TO MEDICATION _____

AUTHORIZATION *(PLEASE SIGN)* I hereby authorize the release of any medical information necessary to process insurance claims and further authorize payment of medical benefits to my physician in the event he/she files insurance for services rendered. I understand I am financially responsible for all charges not covered by my insurance company. I accept responsibility for collection agency fees, attorney fees and court costs should be account be placed for collection.

X _____ Date _____
Patient or authorized person's signature