Dr. David M. Stieber, MD

Patient Information DATE: _____

Name: _____ **Preferred Name**: _____

DOB: ____/____/____ **Sex**: Male Female **Marital Status:** Married Single Widowed

Social Security #: _____ **Driver's License #**:_____

Mailing Address: _____

City:_____ **State**:_____ **Zip Code:**_____

Home Phone: _____**Cell Phone**: _____

Emergency Contact: _____**Phone**: _____

If patient is a Minor: Mother's Name: _____ Father's Name: _____

Mother's Phone: _____ Father's Phone: _____

PROTECTED HEALTH INFORMATION

Individuals who can receive my health information:

Name: _____ Relationship: _____ Phone:_____

Name: _____ Relationship: _____ Phone:_____

Name: _____ Relationship: _____ Phone:_____

You are provided the right to request confidential communications (including communication of Protected Health Information) be made by alternative means other than written correspondence to your home. Please indicate requested methods and provide contact numbers, if applicable.

☐ **HOME PHONE**
☐ Check if we may leave a detailed message. (results, appointment reminders, etc.) ☐ Check if we should leave a call back number only.

☐ **CELL PHONE**
☐ Check if we may leave a detailed message. (results, appointment reminders, etc.) ☐ Check if we should leave a call back number only.

☐ **WORK PHONE**
☐ Check if we may leave a detailed message. (results, appointment reminders, etc.) ☐ Check if we should leave a call back number only.

Would you like appointment reminders sent via email? If so, please include your email address.

_____

PRIMARY INSURANCE

Insurance Company: _____

_____

ID#:_____

Group #: _____

Insured Person/Subscriber Name:

_____

Relationship to insured: _____

Address (if different from insured):

_____

City: _____

ST:_____ ZIP_____

Subscriber Date of Birth: _____

Subscriber Social Security # _____

SECONDARY INSURANCE

Insurance Company: _____

_____

ID#:_____

Group #: _____

Insured Person/Subscriber Name:

_____

Relationship to insured: _____

Address (if different from insured):

_____

City: _____

ST:_____ ZIP_____

Subscriber Date of Birth:_____ Subscriber

Social Security # _____

WORKER COMPENSATION / MOTOR VEHICLE INSURANCE

Insurance Company: Is this **MVA (_____)** or **Worker Compensation (_____)**

Claim Address: _____City:_____ State: _____

Zip Code:_____

Claim # _____

Contact/Adjuster Name:_____

Phone: _____Date of loss/accident/injury:_____

HOW DID YOU HEAR ABOUT US?

- PHONE BOOK
- NEWSPAPER
- INTERNET
- REFERRING PHYSICIAN
- FRIEND
- OTHER

_____

I hereby authorize Dr. David M. Stieber to provide me with medical treatments. I have read, understood, and agree that I am ultimately responsible for all professional and/or technical fees. I hereby assign payment for all medical benefits including major medical benefits to which I am entitled from private insurance and any other health plans to Dr. David M. Stieber. This assignment will remain in effect until revoked by me in writing. I authorize assignee to release all information necessary to secure payment for services.

Patient Signature (or guardian if minor): _____*Date:*_____