

Joseph Hazan, M.D. F.A.C.O.G. New Patient Questionnaire

PERSONAL INFORMATION

Social Security Number

Last Name First Middle Date of Birth

Street Address City Zip Code Home Phone

Emergency Contact Phone Number Relationship

EMPLOYMENT INFORMATION

Work Phone Number

Employer Address Department

PRIMARY INSURANCE

Name of Primary Insurance

Policy Holder Relationship Social Security # Date of Birth

ID # Group Number Policy Holder Employer

SECONDARY INSURANCE

Name of Secondary Insurance

Policy Holder Relationship Social Security # Date of Birth

ID Number Group Number Policy Holder Employer

MEDICAL INFORMATION

Drug Allergies

Current Medications: _____

Surgeries: _____

Medical History _____

Pregnancies: Total Number _____ Live Births: _____

Primary Care Physician: _____ Phone: _____

How did you hear about our practice? _____

ASSIGNMENT: I assign and request payment of full medical benefits to be paid directly to Joseph Hazan, M.D., for all covered services under my health benefit contract and accept responsibility for all non-covered services, including but not limited to co-payments and coinsurance. In addition, my signature attests to the above responses being true to the best of my knowledge.

Signed: _____ Date: _____

RELEASE: I hereby authorize Joseph Hazan, M.D. to furnish complete information as requested by my insurance carriers concerning any illnesses or conditions for which I have been evaluated and treat by this physician.

Signed: _____ Date: _____