

MICHAEL R. HAJEK, MD

INFORMATION SHEET FOR CHILD-PLEASE PRINT

DATE _____

LIST ANY TYPE OF INTERPRETATION OR ACCOMMODATION NEEDS: _____

PATIENT'S FULL NAME _____ FEMALE MALE

SS# _____-_____-_____ BIRTH DATE ____/____/____ AGE _____

ADDRESS _____ CITY _____ STATE ____ ZIP _____

TELEPHONE (____) _____-_____ CELL (____) _____-_____

EMPLOYER _____

EMPLOYER'S ADDRESS _____ CITY _____ STATE ____ ZIP _____

WHICH PHYSICIAN REFERRED YOU TO THIS OFFICE? _____

CITY _____ STATE _____ (WHERE THIS PHYSICIAN PRACTICES)

WHO IS YOUR PRIMARY CARE PHYSICIAN? _____

CITY _____ STATE _____ (WHERE THIS PHYSICIAN PRACTICES)

IS THIS INJURY WORK RELATED? YES NO

IS THIS INJURY AUTO RELATED? YES NO

SHOULD AUTO BILLS BE SENT TO YOUR HEALTH INSURANCE? YES NO

IF THE BILLS SHOULD BE SENT TO A WORK COMP OR AUTO INSURANCE, PLEASE ANSWER FOLLOWING;

WORK COMP/ AUTO INSURANCE COMPANY NAME _____

CLAIM NO. _____ TELEPHONE (____) _____-_____

WHO IS YOUR WORK COMP OR AUTO ADJUSTER? _____

RESPONSIBLE PARTY INFORMATION

MOTHER'S NAME _____ TELEPHONE (____) _____-_____

ADDRESS _____ CITY _____ STATE ____ ZIP _____

MOTHER'S EMPLOYER _____ CITY _____ STATE ____ ZIP _____

MOTHER'S DATE OF BIRTH ____/____/____ MOTHER'S SS# _____-_____-_____

EMAIL ADDRESS: _____

FATHER'S NAME _____ TELEPHONE (____) _____-_____

ADDRESS _____ CITY _____ STATE ____ ZIP _____

FATHER'S EMPLOYER _____ CITY _____ STATE ____ ZIP _____

FATHER'S DATE OF BIRTH ____/____/____ FATHER'S SS# _____-_____-_____

EMAIL ADDRESS: _____

If neither parent is present (with the child) during the office visit we will need the information (on the back side of this page) on the adult that is with the child during the office visit.

*******PLEASE TURN FORM OVER AND COMPLETE THE OTHER SIDE*******

NAME OF OTHER ADULT PRESENT WITH CHILD TODAY: _____
 RELATIONSHIP TO CHILD / PATIENT _____
 ADDRESS _____ CITY _____ STATE _____ ZIP _____
 DATE OF BIRTH ____/____/____ SS# _____-_____-_____
 TELEPHONE (____) _____-_____

DOES YOUR INSURANCE COMPANY REQUIRE A REFERRAL FOR THIS VISIT? ____ YES ____ NO

INSURANCE INFORMATION

PRIMARY INSURANCE _____ EFFECTIVE DATE ____/____/____
 -POLICY NO. _____ GROUP NO. _____
 -POLICY HOLDER'S NAME _____ RELATIONSHIP _____
 -POLICY HOLDER'S EMPLOYER _____
 -POLICY HOLDER'S BIRTH DATE ____/____/____ AGE ____ SS# _____-_____-_____
 LIST INSURED POLICY HOLDER'S ADDRESS (if different) _____
 CITY _____ STATE _____ ZIP _____ TELEPHONE (____) _____-_____

SECONDARY INSURANCE _____ EFFECTIVE DATE ____/____/____
 -POLICY NO. _____ GROUP NO. _____
 -POLICY HOLDER'S NAME _____ RELATIONSHIP _____
 -POLICY HOLDER'S EMPLOYER _____
 -POLICY HOLDER'S BIRTH DATE ____/____/____ AGE ____ SS# _____-_____-_____

CONSENT FOR CARE: I give my consent to all health care services performed by Dr. Michael R. Hajek's medical staff and/ or employees, including diagnostic procedures, medications, injections and other procedures or services given as ordered by our physician. I understand that Dr. Michael R. Hajek participates in training programs for health care personnel. Some patient services may be provided by persons in training under the supervision and instruction of our physicians or employees.

I understand and acknowledge that my insurance coverage is a contract between my insurance company and me and the I am personally responsible for all medical expenses incurred during evaluation and treatment with Dr. Michael R. Hajek. I understand that as a courtesy my primary insurance will be billed; however, it is my responsibility to follow up on delinquent claims.

If I am a member of a PPO or HMO I am required to make my co-pay and co-insurance payments at the time of service, and I am responsible for keeping my primary care referrals current. I understand that I am responsible for paying any charges which insurance does not pay as a result of my not obtaining a referral from my primary care physician.

I assign all benefits from said claims to Dr. Michael R. Hajek. I further agree that a photocopy of this agreement shall be as valid as the original.

I authorize Dr. Michael R. Hajek to release all necessary medical information to the PCP and referring physician listed on the front of this form and to my insurance carrier for processing my claims.

 Patient or Responsible Party's Signature Date ____/____/____

