Joseph J. Schwartz, M.D.

Name _____ Date of Birth ____/____/____ M/F

Address _____ Age____

City_____ State_____ Zip _____

Phone (H) _____ Phone (W)_____

Emergency Contact: Name_____ Phone _____

Insurance Information

Co-Pay $ ____

Insurance Company _____

ID# _____ Group # _____

Subscriber of Insurance_____ Relationship_____

Date of Birth ____/____/____ Phone (H) _____

Secondary Insurance_____

ID# _____ Group # _____

Subscriber of Insurance_____ Relationship_____

Date of Birth ____/____/____ Phone (H) _____

Primary Doctor _____ Phone _____ Fax _____

Address _____

How did you hear about our practice? _____

Assignment and release: I hereby authorize my insurance benefits be paid directly to the physician and acknowledge that I am financially responsible for any unpaid balances. I also authorize the physician to release any information required by the insurance company, including medical records. I understand that I am financially responsible for all charges, whether or not covered by insurance.

Signed_____ Date ____/____/____