CJSOC – ANDREW HARRISON, M.D.

Name: _____ **Date of Birth:** _____

Home Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Age:** _____ **Sex:** ___M ___F **Ethnicity:** _____

Cell Phone: _____ **Relationship Status:** ___Married ___Single ___Widowed ___Divorced

Race: __Caucasian __African American __Hispanic __Asian __ American Indian or Other: _____

Employer's Name: _____ **Work Phone #:** _____

Social Security #: _____-_____-_____ **Occupation:** _____

Primary Care Doctor (First & Last Name) _____ **Phone #:** _____

Referring Physician: _____ **Referral Phone #:** _____

Worker's Comp Injury? **Y [ ] N [ ]** Motor Vehicle Accident? **Y [ ] N [ ]** **Date of Accident:** _____

How did you find Dr. Harrison? _____

Emergency Contact: _____ **Phone #:** _____ **Relationship:** _____

Parent / Guardian / Spouse Information

Name: _____ **Date of Birth:** _____

Home Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone #: _____ **Work Phone #:** _____ **SS#:** _____-_____-_____

Employer Name: _____

Primary Insurance

Name of Insurance: _____ **ID #:** _____

Insured's Name: _____ **Group #:** _____

Insured's Date of Birth: _____ **Insured's SS#:** _____-_____-_____

Secondary Insurance

Name of Insurance: _____ **ID #:** _____

Insured's Name: _____ **Group #:** _____

Insured's Date of Birth: _____ **Insured's SS#:** _____-_____-_____

Medicare Lifetime Signature on File:
I request that payment of authorized Medicare benefits be made on my behalf to, CJSOC-Andrew Harrison, M.D. for any services furnished to me by the physician. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents, any information required to determine that these benefits are payable for related services.

_____ _____

Patient Signature **Date**

*** Private Insurance Authorization for Assignment of Benefits/Information Release:**
I, the undersigned, authorize payment of medical benefits to, CJSOC-Andrew Harrison, M.D. for any services furnished to me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agents information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims and benefits.

_____ _____

Patient, Parent or Guardian Signature (if child is under 18 years old) **Date**