Michael Hirt, M.D.,
A Professional Corporation

PATIENT INFORMATION SHEET

Date: _____ / _____ /_____ Account #:_____

First Name:_____ MI:_____ Last Name:_____

Address:_____

City:_____ State:_____ ZIP code _____ - _____

Home Phone: ( ) _____- _____ Work Phone: ( ) _____- _____ Extension: _____

Cell Phone: ( ) _____- _____ E-mail address:_____ @ _____

I am interested in receiving Dr. Hirt's E-mail newsletters and other health related information. ____Yes ___No

Birthdate: _____ / _____ / _____ Sex: M / F Marital Status: ____Married ____Single ____ Widowed ____ Divorced

Driver's License:_____ State:_____ Social Security Number:_____ - _____ -_____

Employer:_____ Position:_____

Employer's Address:_____

City:_____ State:_____ ZIP code _____ - _____

Spouse's Name:_____ DOB:____ / _____ /_____ SS#:_____ - _____ - _____

Insurance Company:_____ Member Number:_____

Address:_____ Group Number:_____

Secondary Insurance Co:_____ Member Number:_____

Address:_____ Group Number:_____

In Case of Emergency Contact: _____ Phone:_____ Relationship:_____

Referred by:_____ May we thank them for the referral? ___yes ___no

Assignment of Benefits

To:_____

Name of Insured:_____

Name of Patient:_____

I hereby authorize Michael Hirt, M.D., A Professional Corporation to furnish information to insurance carriers concerning me. I hereby irrevocably assign all benefits from government, private, and/or personal policies for medical services rendered to be paid directly to the Michael Hirt, M.D., A Professional Corporation in accordance with California Insurance Code 10133.

I further understand and acknowledge that all professional services rendered are directly charged to and the responsibility of the patient. It is further understood that services are not rendered on the basis that the Insurance Companies will pay the fees.

_____ _____

Insured's Signature Date