Stuart Glassman, M.D., F.A.C.S. 840 Fleming Street Hendersonville NC 28791 828-698-0581

PATIENT INFORMATION (Please Print)

Full Name ______________________ SS# ____________ DOB __________ Age ________

Home Address ______________________ City____________ State _________ Zip ________

Mailing Address (If different) ____

Home Phone ________________ Cell Phone _______________ Work Phone ____________________

Employer/School ______________________________ Marital Status (Circle one) M W S D Sex (Circle one) Male Female

In Case of Emergency Notify: __________________________ Relationship __________ Phone __________

Responsible Party for Payment or to authorize Medical Treatment (if patient is a minor under 18 or 25 if full time student)

Name ______________________________ SS#____________________ DOB ____________________

Relationship to Patient ________________________ Employer of Responsible Party ____________________

Insurance Information

Are you being seen as a result of an accident or injury? (circle one) No Yes Is this Worker's Comp? (circle one) Yes No

Primary Insurance

Name of Insurance Co. ______________________

Insured Party ____________________________

Relationship to patient ______________________

ID/SS#_______________ Effective date _______

Employer Name ______________ Group # ______

Employer Phone ___________________________

Secondary Insurance

Name of Insurance Co. __________________________

Insured Party ________________________________

Relationship to patient ___________________________

ID/SS# ___________________Effective Date _________

Employer Name ______________________________

Employer Phone ______________________________

Authorization to Pay Benefits and/or Release Medical Information (Please read carefully)

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO STUART GLASSMAN, M.D. FOR ANY SERVICES FURNISHED TO ME. I ALSO AUTHORIZED THE RELEASE OF MY MEDICAL INFORMATION TO MY INSURANCE COMPANY IN ORDER TO PROCESS CLAIMS AND TO ANY OTHER MEDICAL PROVIDER OR MEDICAL ENTITY TO WHICH I MAY BE REFERRED FOR FURTHER TREATMENT, CONSULTATION OR MEDICAL SUPPLIES.

SIGNED ______________________________ DATE _______________________

MEDICAL LIFETIME SIGNATURE ON FILE

I REQUEST PAYMENT OF AUTHORIZED MEDICARE BENEFITS TO BE MADE TO STUART GLASSMAN, M.D. FOR ANY SERVICES FURNISHED TO ME BY THE PHYSICIAN. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS, ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS PAYABLE FOR RELATED SERVICES.

SIGNED ________________________________ DATE _____________________