

**Barbara A. Hrach M.D.**  
*Internal Medicine*

**General Information**

Please Print

<u>Personal Information</u>	Date of Birth: / /
Name: _____	
Address: _____	
Phone: _____	Cellular: _____
E-mail: _____	Social Security #: / /

Employment Information

Place of Employment: \_\_\_\_\_

Phone: \_\_\_\_\_

May we contact you at work:    Yes \_\_\_\_\_    No \_\_\_\_\_

Emergency Contact Information

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_                      Cellular: \_\_\_\_\_

E-mail Authorization Information

I hereby authorize the above named physician to send my medical information via E-mail. This authorization will remain in effect until revoked by me in writing. A photocopy of this authorization will be considered as valid and original.

Patient Signature: \_\_\_\_\_                      Date: \_\_\_\_\_

**Insurance Information**

Primary

Please provide receptionist with your insurance card so we can make a copy for our records.

Name of Carrier: \_\_\_\_\_

Carrier's Social Security #: \_\_\_\_\_

Relationship to Carrier:    Self: \_\_\_\_\_    Spouse: \_\_\_\_\_    Child: \_\_\_\_\_

Name of Insurance: \_\_\_\_\_

Address: \_\_\_\_\_                      Group #: \_\_\_\_\_

Phone: \_\_\_\_\_                      Policy #: \_\_\_\_\_

ID #: \_\_\_\_\_

Secondary

Name of Carrier: \_\_\_\_\_

Carrier's Social Security #: \_\_\_\_\_

Relationship to Carrier:    Self: \_\_\_\_\_    Spouse: \_\_\_\_\_    Child: \_\_\_\_\_

Name of Insurance: \_\_\_\_\_

Address: \_\_\_\_\_                      Group #: \_\_\_\_\_

Phone: \_\_\_\_\_                      Policy #: \_\_\_\_\_

ID #: \_\_\_\_\_