

Haydee Docasar, M.D.

www.haydeedocasarmd.com

DEMOGRAPHIC & INSURANCE INFORMATION

CONFIDENTIAL

- ANNUAL UPDATE
 INFORMATION CHANGE

PLEASE PRINT

FULL NAME: _____ **DATE OF BIRTH:** _____
AGE: _____ SINGLE MARRIED DIVORCED OTHER: _____
SOCIAL SECURITY NUMBER: _____ **EMAIL:** _____
ADDRESS: _____ **APT/SPACE/UNIT #:** _____
CITY: _____ **STATE:** _____ **ZIP:** _____
HOME PHONE: () _____ **CELL: ()** _____ **WORK: ()** _____
EMPLOYER: _____

PRIMARY INSURANCE: _____ **POLICY #:** _____ **GROUP #:** _____
GUARANTOR INSURANCE INFORMATION: Self Spouse Parent
GUARANTOR NAME: _____ **DOB:** _____ **SS#:** _____
ADDRESS: _____ **APT/SPACE/UNIT #:** _____
CITY: _____ **STATE:** _____ **ZIP:** _____
EMPLOYER: _____ **PHONE:** _____

SECONDARY INSURANCE: _____ **POLICY #:** _____ **GROUP #:** _____
GUARANTOR INSURANCE INFORMATION: Self Spouse Parent
GUARANTOR NAME: _____ **DOB:** _____ **SS#:** _____
ADDRESS: _____ **APT/SPACE/UNIT #:** _____
CITY: _____ **STATE:** _____ **ZIP:** _____
EMPLOYER: _____ **PHONE:** _____

PERSON TO NOTIFY IN CASE OF EMERGENCY: _____

PHONE: _____ **RELATIONSHIP TO PATIENT:** _____

- I agree to be notified via e-mail regarding updates/announcements in the practice.
 I do not agree to be updated via e-mail.

*Note: We do not give your email or personal information to any third parties.

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Reference Laboratory

Which laboratory is contracted with your Insurance company. Please circle below.

We do not check laboratory benefits.

****Please check with your insurance regarding lab processing and lab draw benefits****

QUEST LAB CORP LMC CPL I DON'T KNOW: INITIAL_____

My signature below indicates that the above information is accurate.

Signature: _____ Date: _____

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