Matthew A. Berger, MD, PC

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INTAKE INFORMATION

Name _____ **Home Phone** _____
First Middle Last

Cell Phone _____

Address _____
Street City County State Zip

Age	Date of Birth	Marital Status	Race	Social Security Number

Place of Employment _____ **Occupation** _____

Work Address _____ **Work Phone** _____

Name of Spouse/Guardian _____ **Place of Employment** _____

Work Address _____ **Work Phone** _____

EMERGENCY INFORMATION

Who May We Contact In Case Of Emergency:

Name _____ **Relationship** _____ **Phone** _____

Next of Kin:

Name _____ **Relationship** _____ **Phone** _____

Primary Care Physician _____ **Phone** _____

Pharmacy _____ **Address** _____ **Phone** _____

Do you have a POA or Advanced Directive? **Yes** ☐ **No** ☐

Name _____ **Relationship** _____ **Phone** _____

INSURANCE INFORMATION

Primary Insurance _____ **ID #** _____

Address _____ **Phone** _____

Subscriber's Name _____ **Relationship to Policyholder** _____

Subscriber's Date of Birth _____ **Subscriber's SSN** _____

Subscriber's Employer _____ **Address** _____

Secondary Insurance _____ **ID #** _____

Address _____ **Phone** _____

Subscriber's Name _____ **Relationship to Policyholder** _____

Subscriber's Date of Birth _____ **Subscriber's SSN** _____

Subscriber's Employer _____ **Address** _____

WORKMAN'S COMPENSATION / ACCIDENT RELATED INSURANCE INFORMATION

PLEASE CIRCLE ONE: **Workman's Compensation** **Auto Related**

Date of Injury _____ **Date of Accident** _____

Place of Employment _____ **Address** _____

Work Phone _____ **Contact Person** _____

Workman's Compensation or Auto Related Insurance Information:

Insurance Name _____ **Address** _____

Insurance Phone _____ **Claim #** _____

Adjuster Name _____ **Adjuster Phone** _____

***PLEASE NOTE:**

All Insurance Information must be completed in order to bill your insurance company.
Any missing information may result in your claim being denied. You will be responsible for full payment.

PLEASE READ AND SIGN:

I understand and agree that I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on this form and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information. I authorize Matthew A. Berger, MD, PC to release to my referring physician or primary care provider a copy of my initial evaluation and treatment plan and/or any follow-up progress note. I understand this authorization will remain in effect unless I revoke this authorization by written request.

Patient Signature* _____ **Date** _____

Legal Guardian Name** _____

Legal Guardian Signature** _____ **Date** _____

*If patient is **14 or older**, patient must sign all paperwork and add legal guardians to their HIPAA.

If patient is **13 or under, a legal guardian must sign all paperwork.

If you have any questions, please ask our staff.