East Jefferson Family Practice

DUNG MICHAEL TRAN, MD
ALEX HOANG, MD
CHARLIE LE, MD
TAI NGUYEN, MD
SARAH SCHWERTNER, MD

PHONE: (504) 885-2505
FAX: (504) 885-2510

WEB: www.ejfamilypractice.com

PATIENT INFORMATION:

Name:_____
(LAST) (FIRST) (MIDDLE)

DOB:_____/ _____/_____ __ GENDER: ☐ MALE ☐ FEMALE SSN:_____-_____-_____

Home Address:_____

City:_____State:_____Zip:_____

EMAIL:_____

Home Phone#:_____-_____-_____Cell Phone#:_____-_____-_____Work Phone#:_____-_____-_____

GUARDIAN/EMERGENCY CONTACT INFORMATION:

Name:_____

Home Address (If different from patient):_____

City:_____State:_____Zip:_____

SSN: _____-_____-_____ Relationship to patient:_____

Home Phone#:_____-_____-_____Cell Phone#:_____-_____-_____Work Phone#:_____-_____-_____

PRIMARY INSURANCE INFORMATION:

Insured's Name:_____Insured's DOB:_____/ _____/_____

Insured's relationship to patient:_____

Insured's SSN: _____-_____-_____ Insured's Phone#:_____-_____-_____

Insured's Place of Employment:_____Employment Phone#:_____-_____-_____

Insurance company name:_____ Insurance company's phone#:_____-_____-_____

Policy #:_____Group #:_____

SECONDARY INSURANCE INFORMATION:

Insured's Name:_____Insured's DOB:_____/ _____/_____

Insured's relationship to patient:_____

Insured's SSN: _____-_____-_____ Insured's Phone#:_____-_____-_____

Insured's Place of Employment:_____Employment Phone#:_____-_____-_____

Insurance company name:_____Insurance company's phone #:_____-_____-_____

Policy #:_____Group #:_____

I REQUEST PAYMENTS OF AUTHORIZED INSURANCE/MEDICARE BENEFITS BE MADE ON MY BEHALF TO EAST JEFFERSON FAMILY PRACTICE, LLC, DUNG (MICHAEL) TRAN, M.D., CHARLIE LE, M.D., OR DUNG (ALEX) HOANG, M.D. TAI NGUYEN, M.D. AND SARAH SCHWERTNER,M.D.FOR ANY SERVICES FURNISHED TO ME BY THAT PROVIDER. I AUTHORIZED ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO MY INSURANCE CARRIER/CMS (CENTER FOR MEDICARE AND MEDICAID SERVICES) AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS PAYABLE FOR RELATED SERVICES. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ANY BENEFITS NOT COVERED BY MY INSURANCE.

Signature_____Date_____

DUNG MICHAEL TRAN, MD
ALEX HOANG, MD
CHARLIE LE, MD
TAI NGUYEN, MD
SARAH SCHWERTNER, MD

PHONE: (504) 885-2505
FAX: (504) 885-2510

WEB: www.ejfamilypractice.com

SIGN HERE