Hawthorne Family Practice

In order to submit claims on your behalf, we require the following information. All information is strictly confidential and HIPPA Compliant

Please make sure you have chosen a Doctor from our practice Dr Enas Tuppo as your Primary Care Physician(PCP)if your plan requires one.

Patient Name:_____ Date of Birth_____
Nick Name:_____ Patient SS#_____-_____-_____Male( ) Female ( )
Address_____
City_____State_____Zip_____
Patient Phone Number ( )_____ Cell ( )_____
Patient Employer:_____
Employer Address:_____
Employer Phone Number:( )_____ext._____

Who can we thank for your referral to our office?_____

Whom shall we call in an emergency:_____
Phone number: ( )_____ Cell ( )_____
Relationship to you: ( ) Spouse/Partner ( ) Parent ( ) Relative ( ) Friend

Person responsible for the bill (if different from patient or if a minor child)
Guarantor Name:_____Guarantor DOB_____
Relationship to Patient: ( ) Self ( ) Spouse /Partner ( ) Parent

PRIMARY INSURANCE INFORMATION
Policy Holder's Name:_____
Policy Holder's DOB:_____Policy Holder's SS#_____
Policy Holder's Employer:_____
Employer Address:_____
Employer Phone Number ( )_____ext_____

SECONDARY INSURANCE INFORMATION
Policy Holder's Name:_____
Policy Holder's DOB:_____Policy Holder's SS#_____
Policy Holder's Employer:_____
Employer Address:_____
Employer Phone Number ( )_____ext_____

***** I authorize the release of any medical information necessary to process OR inquire about this bill to my insurance company, and request payment of benefits to HAWTHORNE FAMILY PRACTICE. I acknowledge that I am financially responsible for payment whether or not covered by insurance.*****

Signature:_____Date:_____