

300 East Main Street • Hummelstown, PA 17036 (p) 717.566.1100 • (f) 717.566.0600

PATIENT INFORMATION SHEET

Name		SS		DOB			
(Last)	(First)	(Initial)					
Address		City	State	Zip			
Home	Work		Cell Phone				
Email address							
Local Pharmacy		Mail Order					
Primary Insurance		ID#					
Group	Subscribe	r	Relationship				
DOB	Employer_						
Subscriber A	ddress if different from	above					
I ACKNOWLEDGE I RECEI	VED THE NOTICE OF PE	RIVACY PRACTICES	FOR Todd R. Fisher, I	M.D.			
Patient or Responsible Party							
I authorize and request my payable to me. I understan	or my child during the po insurance company to pay d that my insurance carri	eriod of such care to y directly to the doct er may pay less thar	third party payors and/ or or doctor's group insu the actual bill for service	or other health practitioners.			
		Date					
Patient's or Authorized Pers	on's Signature						
PERMISSION FOR DIAGNO I hereby give permission to torender treatment.			., Family Medicine to per	form such diagnostic studies,			
Patient or Responsible Party	7	Date	Witness				
	Emerge	ency Contact					
Relationship to Patient	Relatio	nship	Phone				
	Emerg	Emergency Contact					
	Relatio	onship	Phone				