Daniel F. Haber M.D.
Orthopedic Surgery
Sports Medicine

Please print clearly _____ **Date** _____

Medical Information

Are you here for an: ☐ Initial visit ☐ 2nd opinion ☐ New Problem
Reason for today's visit _____ ☐ Left ☐ Right
When did it happen/Date of injury? _____
How did it happen? _____
How did you hear about us/who referred you _____
Is your injury worked related ☐ No ☐ Yes
All previous operations _____
Current medications _____
All drug allergies _____
_____

Patient Information

Name _____ SSN _____
Address _____ City State & Zip _____
Date of Birth _____ Gender ☐ Male ☐ Female
Phone _____ Cell Phone _____ Email _____
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
If a dependant: Parent Name _____ DOB _____ SSN _____
_____

Employment Information

Employer of insured _____ Phone _____
Address _____
_____

Insurance Information

Primary _____ Effective Date _____
Address _____
ID _____ Group _____
*Subscriber _____ DOB _____ SSN _____

Secondary _____ Effective Date _____
Address _____
ID _____ Group _____
*Subscriber _____ DOB _____ SSN _____

Workers' Compensation _____
Address _____
Date of Injury _____ Claim Number _____
Adjustor _____ Phone _____ Fax _____

I authorize treatment for the above named patient:

Signature: _____ Date: _____

*Be sure to complete the subscriber information if someone other than the patient is the subscriber; this information is necessary for billing purposes.