WELCOME TO THE OFFICE OF HAKAN M. KUTLU, M.D.

Reason for visit:_____

Referred by:_____

Patient Name:_____ SS#:_____-_____-_____

Birthdate:_____-_____-_____ Marital Status: S M W D Age:_____

Address:_____ City:_____

State:_____ Zip:_____ Email address: _____

Home Phone #:_____Work Phone#:_____ Cell Phone #:_____

Emergency Contact:_____Relationship:_____ Phone#:_____

Family Doctor:_____ Phone#:_____

Pharmacy:_____ Phone#:_____

Employer's Name & Address:_____

Occupation:_____

Primary Ins.:_____ Policyholder Name:_____

Birthdate:_____ SS#:_____

Secondary Ins:_____ Policyholder Name:_____

Birthdate:_____ SS#:_____

HIPAA Approved Contacts

Name:_____ Relationship:_____ Phone#:_____

Address:_____ City:_____ State:_____ Zip:_____

Name:_____ Relationship:_____ Phone#:_____

Address:_____ City:_____ State:_____ Zip:_____

I understand and agree that health and accident policies are an arrangement between and insurance carrier and myself. Furthermore, I understand that the Doctor's office will provide any necessary reports and forms to assist me in making collection from the insurance company. I authorize the insurance company to pay directly to Hakan Kutlu, M.D. the amount due my pending claim for services rendered. I understand and agree all services rendered me and charged to me and that I am personally responsible for their payment as well as any applicable fees incurred due to collection or legal actions. **If referred for collection, a 33% collection fee will be added to the outstanding amount.** I realize that non-covered balances are my responsibility.

By my signature below, I authorize Hakan M. Kutlu M.D. to file a complaint with NJ Dept. of Banking and Insurance regarding my insurance claims if deemed necessary.

Patient Signature:_____ Date:_____