

DATE ____/____/____

PATIENT INFORMATION SHEET

NAME _____ SEX ____ AGE ____ BIRTHDAY ____/____/____
STREET ADDRESS _____ SOC. SEC. # ____-____-____
CITY _____ ZIP CODE _____ HOME PHONE # _____
EMAIL ADDRESS _____ CELL PHONE # _____
OCCUPATION/EMPLOYER _____ WORK PHONE # _____
PRIMARY PHYSICIAN _____ WHO REFERRED YOU HERE? _____
MARITAL STATUS ____ NAME OF SPOUSE/PARENT _____
NAME OF PERSON RESPONSIBLE FOR BILL _____
IN CASE OF EMERGENCY CALL _____ PHONE # _____
HIPPA CONTACT _____ RELATIONSHIP _____
PHARMACY NAME _____ PHONE # _____

INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER _____ SUBSCRIBER _____
POLICY # _____ GROUP # _____
SUBSCRIBER BIRTHDATE ____/____/____ SUBSCRIBER SOC. SEC. # ____-____-____
SECONDARY INSURANCE CARRIER _____ SUBSCRIBER _____
POLICY # _____ GROUP # _____
SUBSCRIBER BIRTHDATE ____/____/____ SUBSCRIBER SOC. SEC. # ____-____-____

MEDICARE PATIENTS: PLEASE SIGN AND DATE

I CERTIFY THAT THE INFORMATION GIVEN BY ME IN APPLYING FOR PAYMENT UNDER TITLE XVII OF THE SOCIAL SECURITY ACT IS CORRECT. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION OR ITS CURRIES, ANY INFORMATION REQUIRED TO PROCESS MY MEDICARE CLAIMS. I REQUEST THAT PAYMENT UNDER THE MEDICAL INSURANCE PROGRAM BE MADE WITHER TO ME OR TO MARY LOUISE LENAHAH MD FOR SERVICES PROVIDED TO ME DURING THE PERIOD FROM MY FIRST VISIT TO TERMINATION OF TREATMENT.

SIGNATURE OF MEDICARE BENEFICIARY

DATE

MEDICARE NUMBER

EFFECTIVE DATE