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 REFFERED 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 LENAHAN 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