

## Patient Information Form

Patient Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_

Name you prefer to be called: \_\_\_\_\_

Patient Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M F

### **Employment Information:**

Patient Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Work phone No: \_\_\_\_\_ Ext. \_\_\_\_\_

Social Security: \_\_\_\_\_ Drivers License: \_\_\_\_\_

### **In Case of Emergency:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Patient's Spouse: \_\_\_\_\_ Phone: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

**Referred by:** \_\_\_\_\_

**Insurance Information:**

*Please provide your insurance information so that we may submit it for any lab work needed:*

**Insurance Name:**

ID: \_\_\_\_\_ Group ID: \_\_\_\_\_

Relation to Insured: \_\_\_\_\_

Insured(s) Name if not you: \_\_\_\_\_

Insured(s) Employer Info if not you: \_\_\_\_\_

Insurance Phone Number: \_\_\_\_\_

**Financial Policy:**

Thank you for selecting Dr. Abby Bleistein for your health care needs. We are honored to be of service to you and your family. This is to inform you of our billing requirements and our financial policy. Please be advised that payment for all services will be due at the time services are rendered, unless prior arrangements have been made. For your convenience, we accept Visa, MasterCard, Discover Card, and checks.

I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney's fees and court costs.

I have read and understand all of the above and have agreed to these statements.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date