PATIENT INFORMATION

Today's Date_____

PROVIDER: ALAN H BRILL

PATIENT NAME: _____ _____ _____ // _____
LAST FIRST MIDDLE PREFERRED

ADDRESS: _____ SEX: [ ] FEMALE [ ] MALE

ZIP CODE: _____ HOME #: _____ CELL #: _____

EMAIL: _____ SOCIAL SECURITY NUMBER: _____

DATE OF BIRTH: _____ MARITAL STATUS: [ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Other

RESPONSIBLE (OR INSURED) PARTY INFORMATION

RELATIONSHIP TO THE RESPONSIBLE PARTY: [ ] SELF (Skip to Next Section) [ ] SPOUSE [ ] CHILD [ ] OTHER

RESP. PARTY NAME: _____ _____ _____
LAST FIRST MIDDLE

ADDRESS: _____ ZIP: _____

DATE OF BIRTH: _____ SSN: _____ SEX: [ ] FEMALE [ ] MALE

HOME PHONE #: _____ CELL PHONE #: _____ EMAIL: _____

INSURANCE INFORMATION

1) PRIMARY INSURANCE COMPANY NAME: _____

ADDRESS: _____

PHONE #: _____ ID#: _____ GROUP #: _____

PATIENT RELATIONSHIP TO SUBSCRIBER: [ ] SELF (Go to Next Section) [ ] SPOUSE [ ] CHILD [ ] OTHER

SUBSCRIBER'S NAME: _____ SUBSCRIBER'S DATE OF BIRTH: _____

COORDINATION OF CARE INFORMATION

PRIMARY CARE PHYSICIAN: _____ REFERRED BY: _____

PHARMACY: _____ PHARMACY ADDRESS -**OR**- PHONE#: _____

ALLERGIES: _____

PATIENT CONSENT

I AGREE TO ALL HIPAA, FINANCIAL, MEDICAL TREATMENT, CONTACT, AND ANY OTHER CONSENTS REQUIRED IN ORDER TO RECEIVE A MEDICAL EXAMINATION BY DR. ALAN BRILL. COPIES OF THESE CONSENT FORMS CAN BE VIEWED AND PRINTED ON THE PRACTICE WEBSITE www.AlanBrillMD.com, REQUESTED VIA THE PATIENT PORTAL, OR REQUESTED BY OFFICE STAFF AT A LATER DATE. THIS SIGNATURE SERVES AS CONSENT FOR ALL RELATED DOCUMENTS IN EFFECT ON THIS DATE.

SIGNATURE: _____

EXAM

NOSE: _____

MOUTH: _____

EARS: _____
[ ] EARS CLEANED/CERUMEN REMOVED

OTHER: _____

MEDICATIONS PRESCRIBED: _____

TESTS/PROCEDURES/REFERRALS ORDERED: _____

WHEN SHOULD PATIENT SHOULD FOLLOW UP?: _____

CHARGES

VISIT LEVEL (2,3,4): _____ DIAGNOSIS: _____

ADDITIONAL PROCEDURES/CHARGES: _____