Patient Information

TODAY'S DATE: _____

Patient Information

NAME: Rick Shacket
ADDRESS: _____
CITY: _____ **STATE** ___ **ZIP** _____
DID YOU SEE OUR WEBSITE ___ **Yes** ___ **No**
ARE WE IN YOUR PLAN DIRECTORY? ___ **Yes** ___ **No**

EMPLOYER: _____
ADDRESS: _____
CITY/ST/ZIP: _____
PHONE #: _____

AGE: _____ **DATE OF BIRTH:** 1-30-55
SEX: M **MARITAL STATUS:** _____
email: _____
SOCIAL SEC #: _____
DRIVERS LICENSE # _____ **State** _____
PERMANENT ADDRESS: _____
CITY/ST/ZIP: _____
HOME PHONE #: _____
WORK PHONE #: _____
MOBILE PHONE#: _____

Responsible Party Information

NAME: _____
ADDRESS: _____
CITY/ST/ZIP: _____
HOME PHONE: _____
SOCIAL SECURITY #: _____

RELATION TO PATIENT: _____
EMPLOYER: _____
ADDRESS: _____
CITY/ST/ZIP: _____
WORK PHONE: _____

Primary Insurance (Please give your insurance card(s) to the receptionist)

INSURANCE CO.: MHBP
ADDRESS: Mail Handlers Way
CITY/ST/ZIP: Washington DC
PHONE # _____
Effective dates: _____ **through** _____
PLAN NAME _____ **COPAY $** _____

POLICYHOLDER'S NAME: _____
POLICYHOLDER SSN: _____
POLICYHOLDER D.O.B: _____
POLICY #: 567890
GROUP #: _____
RELATION TO PATIENT: _____
POLICYHOLDER'S EMPLOYER: _____

Additional / Secondary Insurance

INSURANCE CO.: _____
ADDRESS: _____
CITY/ST/ZIP: _____
PHONE # _____
Effective dates: _____ **through** _____
PLAN NAME _____ **COPAY $** _____

POLICYHOLDER'S NAME: _____
POLICYHOLDER SSN: _____
POLICYHOLDER D.O.B: _____
POLICY #: _____
GROUP #: _____
RELATION TO PATIENT: _____
POLICYHOLDER'S EMPLOYER: _____

Miscellaneous

In case of emergency, notify _____ **Relation to patient** _____
Home phone _____ **Work phone** _____

Signature

The undersigned verifies that the above information is true and correct.

Signature: _____ **Date:** _____

(If patient is a minor - signature of parent/guardian)