For Office Use Only:	**Seminar Date:** / /
	Non-Seminar: Yes / No
	Appt Date:

Folder #: _____

Patient Information

Patient Name: Date of Birth: SSN #:

Address: City / State / Zip:

Primary Phone: Email:

Primary Phone Type: ¬ Home ¬ Cell Phone ¬ Work Gender: ¬ Male ¬ Female

Secondary Phone:

Secondary Phone Type: ¬ Home ¬ Cell Phone ¬ Work Marital Status: ¬ Single ¬ Married ¬ Divorced ¬ Widow

Employer & Occupation:

Employment Status: [ ] Full Time [ ] Part Time [ ] Self Employed [ ] Disabled [ ] Homemaker
[ ] Student [ ] Retired [ ] Unemployed

How did you hear about us: [ ] Internet [ ] Friend / family [ ] Primary Care Physician [ ] Other:
_____

Primary Care Physician (PCP): PCP Phone Number:

Referring Physician: Referring Phone Number:

Insurance Information

	Primary	Secondary
Insurance Company Name		
Policy Number		
Group Number		
Policy Holder Name		
Policy Holder D.O.B. & SSN		
Policy Holders Employer		

Permission for release of information: To the best of my knowledge, this information and the medical history that I report are correct. I authorize the physicians and staff of Dana L. Reiss, M.D. to release my demographic and medical information to insurance companies as necessary.

Patient Signature Date

Last Edited: 01/15/2013 KA