



Patient's Name

_____ Last _____ First _____ Middle _____

Address _____
Street & Apt # _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Other Phone _____

Any restrictions for contacting you? No Yes E-mail _____
Contact _____ Drivers License # _____
Restrictions: _____ (include State) _____

Age _____ Birthdate ____/____/____ SS# ____ - ____ Sex Female Male

Marital Status Single Married to: _____ Referring Physician: _____

Patient's Employer

_____ Occupation _____

Work Phone _____ Ext: _____ Is it okay to call you at work? Yes No

Address _____
Street & Suite # _____ City _____ State _____ Zip _____

Emergency Contact

(Not in your household) _____ Relationship to Patient _____

Home Phone _____ Work Phone _____ Other Phone _____

Address _____
Street & Apt # _____ City _____ State _____ Zip _____

Primary Health Insurance Company

Policy # _____ Group # _____ Ins. Phone _____

Referral Required? No Yes Copay? No Yes, \$ _____ Employer _____

Primary Policy Holder's Name: _____ DOB _____ Social Security # _____ - ____ - ____

Secondary Health Insurance Company

Policy # _____ Group # _____ Ins. Phone _____

Referral Required? No Yes Copay? No Yes, \$ _____ Employer _____

Primary Policy Holder's Name: _____ DOB _____ Social Security # _____ - ____ - ____

Would you like to receive information about our non-medical services? Yes ____ No ____
May we e-mail you the results of any medical testing done at our office? Yes ____ No ____
May we leave a message on your home answering machine? Yes ____ No ____
May we leave a message for you at work to call us? Yes ____ No ____
May we discuss your medical condition with another person? Yes ____ No ____

If so, whom _____ Relationship _____

I understand that office visit charges are payable on the day service is rendered. I authorize Dr. Trakimas to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Dr. Trakimas and myself.

Signature _____ **Date** _____