WELCOME TO OUR OFFICE

Please complete the following

Date ____________________

Mr. Mrs. Miss Ms Master

Last Name__________________________

First Name__________________________

Middle Initial________________________

Address_____________________________

Town ______________________________

State__________ Zip Code__________

Employer____________________________

Occupation:__________________________

Home Phone_________________________

Work Phone__________________________

Gender: Male_____ Female_____

Date of Birth_________________________

Social Sec #_________________________

Referred By__________________________

<u>If Child</u>: Parents - __________________

School - __________________

Grade - __________________

<u>Insurance Information</u>

Insurance Co.__________________________

Plan Name____________________________

ID #________________________________

Group #______________________________

Insured Name (if different from patient):

____

Insured Birthdate:_____________SS#______________

Insured's Employer_________________________

Additional Insurance________________________

Name on this policy_________________________

Birthdate_____________SS#_______________

ID # __________________________________

Group # ________________________________

Patient's Primary Care Doctor________________

Phone Number:___________________________

I acknowledge that I have received a copy of Dr. Simeone's notice of Privacy Practices. Also, I understand that responsibility for payment for myself or my dependents is mine and payable at the time services are rendered unless other arrangements have been made.

Signed_______________________________