PATIENT INFORMATION
H. GEORGE LEVY, MD PC

PATIENT NAME _____ _____ _____
LAST FIRST MI

ADDRESS _____ _____ _____ _____
STREET CITY STATE ZIP CODE

PHONE _____ SOCIAL SECURITY # _____

DATE OF BIRTH _____ MARITAL STATUS ☐ S ☐ M ☐ D ☐ W

AGE _____ SEX ☐ FEMALE ☐ MALE

REFERRING DOCTOR _____

PHARMACY _____

PARENTS (IF MINOR) _____

FATHER SS# _____ MOTHER SS# _____

EMERGENCY CONTACT _____ PHONE # _____

EMAIL ADDRESS _____

HOW DID YOU HEAR ABOUT US? _____

THE EMAIL ADDRESS PROVIDED WILL BE USED FOR OUR EMAIL MARKETING AT THE OFFICE OF DR. LEVY. YOUR EMAIL ADDRESS WILL NOT BE DISTRIBUTED TO ANYONE. THE PRACTICE SENDS OUT NEWSLETTERS AND COUPONS/DISCOUNTS FOR SERVICES AT OUR OFFICE. YOU ARE ALSO CONSENTING TO RECEIVE ELECTRONIC STATEMENTS BY PROVIDING YOUR EMAIL ADDRESS.

EMPLOYER _____ PHONE # _____

ADDRESS _____

PRIMARY INSURANCE CO ☐ BCBS ☐ MEDICARE ☐ MEDICAID ☐ OTHER ☐ SELF-PAY

POLICYHOLDER NAME _____

DATE OF BIRTH _____ SOCIAL SEC # _____

CONTRACT ID# _____ GROUP # _____

EMPLOYER NAME _____ EMPLOYER PH _____

RELATION TO PATIENT ☐ SELF ☐ SPOUSE ☐ DEPENDENT ☐ OTHER

SECONDARY INSURANCE CO ☐ BCBS ☐ MEDICARE ☐ MEDICAID ☐ OTHER ☐ SELF-PAY

POLICYHOLDER NAME _____

DATE OF BIRTH _____ SOCIAL SEC # _____

CONTRACT ID# _____ GROUP # _____

EMPLOYER NAME _____ EMPLOYER PH _____

RELATION TO PATIENT ☐ SELF ☐ SPOUSE ☐ DEPENDENT ☐ OTHER

ALL COPAY'S ARE PAYABLE AT THE TIME OF SERVICE, I UNDERSTAND AND AGREE THAT (REGARDLESS OF MY INSURANCE STATUS) I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE OF MY ACCOUNT FOR ANY SERVICE RENDERED. I AUTHORIZE DIRECT PAYMENT OF MEDICAL AND SURGICAL BENEFITS TO H. GEORGE LEVY, MD PC. I AUTHORIZE RELEASE OF INFORMATION TO PROCESS ANY INSURANCE CLAIMS SUBMITTED BY H. GEORGE LEVY, MD PC. IF A BIOPSY OR LAB WORK IS PERFORMED ON ME, I AM RESPONSIBLE FOR THE CALLING THE DOCTOR IN A WEEK FOR THE RESULTS.

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PATIENT OR PARENT'S SIGNATURE RELATION TO PATIENT DATE