PATIENT INFORMATION

Patient Name _____ Today's Date ___/___/___

Address _____ Former Name _____

City _____ State _____ Zip _____

Home Phone ( ) _____ Mobile Phone ( ) _____ Work Phone: ( ) _____

Social Security # _____ Birth Date ___/___/___

Email Address: _____ Marital Status: (check one) ☐ M ☐ S ☐ D ☐ W

Employer _____

Referring Physician _____

Referring Dr. Address _____ Phone ( ) _____

Primary Dr. _____

Primary Dr. Address _____ Phone ( ) _____

Primary Insurance Co. _____

ID # _____ Group # _____

Subscriber _____ Birthdate ___/___/___ Relationship to Insured _____

Secondary Insurance Co. _____

ID # _____ Group # _____

Subscriber _____ Birthdate ___/___/___ Relationship to Insured _____

HEALTH INSURANCE/MEDICARE AUTHORIZATION: I authorize the release of any information necessary to process claims on my behalf to Medicare and all other health insurance companies of which I am a beneficiary, and payment of said claims directly to IRENE GREEN HOUSE P.C.

Signature: _____ Date ___/___/___

EMERGENCY CONTACT: In the event of emergency, or if you would like us to discuss your Protected Health Information with a friend or family member, you must provide us with authorization to do so.

You may release my Protected Health Information to: _____
Name of Friend/Relative

Emergency Contact Phone: _____

Relationship to Patient ☐ Spouse ☐ Child ☐ Friend ☐ Other _____

Signature: _____ Date ___/___/___

PLEASE COMPLETE PAGE 2 (REVERSE SIDE) OF THIS FORM. THANK YOU.

RACE, ETHNICITY & PREFERRED LANGUAGE

Please check one selection in each category. We ask these questions to satisfy government requirements. If you object to these questions, you may decline to answer.

Race: ☐ American Indian or Alaska Native ☐ Black or African American ☐ Other Race
☐ Asian ☐ White ☐ Other Pacific Islander
☐ Native Hawaiian ☐ Hispanic ☐ Unreported/Declined to Report

Ethnicity: ☐ Hispanic ☐ Non Hispanic ☐ Unreported/Declined to Report

Preferred Language ☐ English ☐ Spanish ☐ Russian ☐ Indian (includes Hindi & Tamil)
☐ Other

PHARMACY INFORMATION

Local Pharmacy

Name of Pharmacy _____

Address _____

Mail Order Pharmacy

Name of Pharmacy _____

Address _____

LABORATORY INFORMATION

Which laboratory do you typically use?

☐ Quest Diagnostics ☐ LabCorp ☐ Primary Care Physician's Office

☐ Other Name of Lab _____

ACCIDENT INFORMATION

To be completed only if your visit is related to an accident.

☐ AUTO ☐ WORK ☐ CLAIM OPEN VERIFIED WITH _____

Date of Accident ___/___/___ Claim # _____

Place of Accident _____

Insurance Carrier _____

Address _____

Adjuster Name _____ Adjuster Phone ( ) _____

Attorney Name _____ Attorney Phone ( ) _____

Attorney Address _____

_____