M	Y

PATIENT INFORMATION RECORD (please print or write legibly)

PATIENT INFORMATION **DATE**_____ **Male or Female**

NAME_____ **DOB**_____**AGE**_____
ADDRESS_____**SSN**_____
CITY_____**STATE**_____**ZIP**_____
HOME PHONE (____)_____**CELL PHONE (____)**_____
MARITAL STATUS_____**DL#**_____
E-MAIL ADDRESS _____
_____**YES, I WOULD LIKE TO RECEIVE NOTIFICATIONS BY E-MAIL**

OCCUPATION_____**EMPLOYER**_____
EMPLOYER'S ADDRESS_____
CITY_____**STATE**_____**ZIP**_____
OFFICE PHONE (_____)_____

SPOUSE'S NAME_____
SPOUSE'S EMPLOYER_____
SPOUSE'S OFFICE PHONE (_____)_____

PERSON TO CONTACT IN EMERGENCY (other than spouse)
NAME_____
ADDRESS_____
CITY_____**STATE**_____**ZIP**_____
PHONE (_____)_____

INSURANCE INFORMATION

NAME OF PRIMARY INSURANCE COMPANY_____
NAME OF POLICY HOLDER_____**DOB**_____
POLICY ID #_____**POLICY HOLDER SSN**_____
MEDICARE #_____**MEDICAID # (**IF APPLICABLE**)**_____

NAME OF SECONDARY INSURANCE COMPANY_____
NAME OF POLICY HOLDER_____**DOB**_____
POLICY ID #_____**POLICY HOLDER SSN**_____

FEES FOR MEDICAL SERVICES ARE DUE AT THE TIME OF THE VISIT
Please indicate your payment choice: CASH___ CHECK___ VISA/MC___AMEX___DISCOVER___

___I consent to treatment necessary for the care of the patient indicated on this form. Authorization is hereby granted to release information as may be necessary to process and complete my claim.
Signed_____**Date**_____

___I authorize payment of medical benefits to Norman Slusher, M.D.
Signed_____**Date**_____

REFERRAL INFORMATION
PERSONAL PHYSICIAN_____**PHONE**_____
REFERRED BY_____ **PHONE**_____