Brian A Levitt MD LLC

REGISTRATION FORM

Today's Date:	

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:		Race/Ethnicity:

Pharmacy Name and Phone Number or Address:	Marital Status:	Name you go by:	Birth date:	Age:	Sex:
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Who referred you to us?

Address: City: State: Zip:

Social Security number:	Home phone:	Cell phone:
Occupation:	Employer:	Employer phone:
Preferred contact: CELL HOME WORK	Email address:	

Spouse's/Partner's Name:	Spouse's/Partner's Birth date:	Spouse's/Partner's phone number:	Spouse's/Partner's SS# (if policy holder)
Occupation:	Employer:	Employer address:	Employer phone no.:

In a life or death situation, would you accept a blood transfusion?
_____YES _____NO

Thank you for granting permission to take your photo for electronic charts.

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Please indicate primary insurance:

Subscriber's name:	Subscriber's S.S. number:	Birthdate:	Group number:	Policy number:	Co-payment: $

Patient's relationship to subscriber:

Name of secondary insurance (if applicable):	Subscriber's Name:	Group number:	Policy number:

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home/Cell phone:	Work phone:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance**. I understand that payment is expected at the time of service**. I also authorize Brian A Levitt MD LLC or insurance company to release any information required to process my claims.

Patient/Guardian signature Date