Doctor: JOSEPH J FURLIN MD Patient ID# 07/17/2014

PATIENT INFORMATION Date of Birth: ___/___/___ Age: Sex: [ ] M [ ] F

Name: _____ Social Security#: _____

Address: _____ Phone: _____ [ ] Home [ ] Cell [ ] Other

_____ Phone: _____ [ ] Home [ ] Cell [ ] Other

City, State, Zip: _____ Phone: _____ [ ] Home [ ] Cell [ ] Other

Can we leave a voice message of normal test results? [ ] Yes [ ] No If yes, which phone? [ ] Home [ ] Cell [ ] Other

Pharmacy Name & Address: _____ Marital Status: [ ] Married [ ] Single [ ] Divorced

_____ Email Address: _____

Ethnicity: [ ] Hispanic or Latino [ ] Non Hispanic or Latino [ ] Other Preferred Language: _____

Race: [ ] American Indian or Alaska Native [ ] Asian [ ] black or African American [ ] Native Hawaiian or Other Pacific Islander
[ ] White or Caucasian [ ] Other or Undetermined

How were you referred to this office? _____ Spouse's Name _____

Examples: Doctor, Internet, Friend/Family, Hospital, Walk-in or Clinic Spouse's Date of Birth _____

PATIENT EMPLOYMENT INFORMATION

[ ] Employed [ ] Retired [ ] Unemployed [ ] Other

Employer's Name: _____

Employer's Phone: _____

Occupation: _____

Referring Physician: _____

Primary Physician: _____

EMERGENCY CONTACTS (Name, Relationship, and Phone)

_____

_____

Responsible Party (If patient is under 18 years of age)

Name: _____

Address: _____

_____

City, State, Zip: _____

Employer: _____

Home Phone: _____

Work Phone: _____

SSN: _____

Date of Birth: _____

Primary Insurance:

Insurance Company Name: _____

ID#: _____

Group/Policy#: _____

Subscriber's Name: _____

Relationship to Patient: _____

Subscriber's Employer: _____

Subscriber's SS#: _____

Subscriber's Date of Birth: _____

Secondary Insurance:

Insurance Company Name: _____

ID#: _____

Group/Policy#: _____

Subscriber's Name: _____

Relationship to Patient: _____

Subscriber's Employer: _____

Subscriber's Employer: _____

Subscriber's Date of Birth: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT (Please read and sign)

I attest that the information I have given here is correct and true to the best of my knowledge. I hereby assign benefits to be paid directly to the doctor, and authorize him/her to furnish information regarding my illness to my insurance carrier. I understand that I am responsible for any amount not paid for by my insurance.

_____ _____

PATIENT/GUARDIAN SIGNATURE DATE

I authorize the clinic to obtain medication history electronically from my pharmacy benefit administrator.

_____ _____

PATIENT/GUARDIAN SIGNATURE DATE