*NO INSURANCE ACCEPTED

*NO CREDIT CARDS

PATIENT'S CONFIDENTIAL INFORMATION SHEET

PATIENT NAME: ______________________ AGE: ____ DATE OF BIRTH ______________

ADDRESS: ______________________ HOME PHONE: ______________

______________________ PATIENT'S STATUS: ____SINGLE ____STUDENT ____MARI

PATIENT WORK PHONE: ______________ SPOUSE'S WORK PHONE OR DAYTIME# ______________

PATIENT'S OCCUPATION: ______________ EMPLOYER: ______________

PATIENT'S SOCIAL SECURITY: ______________ SPOUSE'S NAME: ______________

PATIENT'S PRIMARY INSURANCE CARRIER: ______________ ID# ______________

GROUP# ______________ Cate gory# ______________ MEDICARE# ______________

NAME OF SECONDARY INSURANCE ______________ ID# ______________

NAME OF PERSON WHO IS THE HOLDER OF INSURANCE: ______________

RELATIONSHIP OF PATIENT TO INSURANCE HOLDER: ____SPOUSE ____CHILD ____SELF ____OTHER ____

** INSURANCE INFORMATION FOR OUTSIDE LAB PURPOSES ONLY, DR. FELIG DOES NOT ACCEPT INSURANCE.**

** PAYMENT IS DUE AT TIME OF SERVICE, SORRY NO CREDIT CARDS ACCEPTED.**

NAME OF PERSON TO CONTACT IN CASE OF EMERGENCY: ______________ RELATIONSHIP ______

PHONE: ______________

NAME OF REFERRING PHYSICIAN: ______________