WELCOME TO OUR OFFICE

NORMAN RIEGEL, MD
DANIEL RIEGEL, MD

PLEASE FILL IN THE FOLLOWING INFORMATION SO WE CAN SERVE YOU PROPERLY

PATIENT'S NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

MARITAL STATUS: _____ PATIENT'S SEX: _____

DATE OF BIRTH: _____ LAST 4 DIGITS OF SOCIAL SECURITY # (XXX – XX – _____)

HOME PHONE: _____ WORK PHONE: _____

CELL OR ALTERNATE NO: _____

EMAIL ADDRESS: _____

NAME OF INSURANCE COMPANY: _____

NAME OF THE POLICY HOLDER: _____

RELATION TO POLICY HOLDER: _____ POLICY NUMBER: _____

GROUP NUMBER: _____ CATEGORY NUMBER: _____

SS# OF INSURED (LAST 4 DIGITS): _____ DOB OF POLICY HOLDER: _____

SECONDARY INSURANCE IF APPLICABLE: _____

RELATION TO POLICY HOLDER OF SECONDARY INSURANCE: _____

POLICY NUMBER: _____ GROUP NUMBER: _____

CATEGORY NUMBER: _____

SS# OF INSURED (SECONDARY) (LAST 4 DIGITS): _____

DOB OF 2ND POLICY HOLDER: _____

NAME AND ADDRESS OF PATIENT'S EMPLOYER: _____

_____

_____

NAME OF YOUR PRIMARY DOCTOR: _____

PHONE NUMBER OF PRIMARY DOCTOR: _____

ADDRESS OF PRIMARY DOCTOR: _____

_____

PHARMACY NAME: _____

PHARMACY PHONE NUMBER: _____

PHARMACY ADDRESS: _____

_____

WHO RECOMMENDED YOU TO OUR OFFICE? _____

NAME AND PHONE NUMBER OF A RELATIVE NOT LIVING WITH YOU: _____

_____

IF YOU CANNOT BE REACHED, IS THERE SOMEONE YOU WOULD LIKE US TO CALL:

_____

_____

I AUTHORIZE THIS OFFICE TO RELEASE ANY INFORMATION NECESSARY TO EXPEDITE INSURANCE CLAIMS. I UNDERSTAND THAT I AM RESPONSIBLE FOR CHARGES REGARDLESS OF INSURANCE COVERAGE.

PATIENT, PARENT OR GUARDIAN SIGNATURE: