WELCOME TO THE OFFICE OF SARA J. REINGANUM, M.D.

Thank you for choosing our office. In order to serve you properly, we will need the following information. **Please print.** All information is strictly confidential.

NAME: ____ [ ] MALE [ ]FEMALE
Last *First* *Middle*

BIRTHDATE: _______________ AGE: _______ MARTIAL STATUS: [ ] S [ ] M [ ] W [ ] D

ADDRESS: ____
Street Address ***(Not a P.O. Box)*** *City* *Zip Code*

HOME PHONE: (____)__________________ SOCIAL SECURITY # __________________

BEST NUMBER TO REACH YOU: (____)____________________________

EMPLOYER: ______________________________ WORK PHONE: (____)___________

EMPLOYER ADDRESS: ____
Street *City* *Zip Code*

SPOUSE/PARENT Information: ____
Last Name *First Name*

BIRTHDATE: ____________________ SOCIAL SECURITY # ________________________

EMPLOYER: ___________________________ WORK PHONE: (____)________________

EMPLOYER ADDRESS: ____
Street *City* *Zip Code*

Which physician referred you? ____

Who is your primary care physician? ____

EMERGENCY CONTACT: ____________________________ PHONE # (___)_____________

Will an insurance company cover your medical services? [ ] Yes [ ] No, I will be paying in full today

Primary Insurance Company: ____

I.D. # ________________________________ GROUP #: __________________
Subscriber is : [ ] *Patient* [ ] *Spouse* [ ] *Father* ___________ [ ] *Mother* ________

Secondary Insurance Company*:* ____

I.D. # ________________________________ GROUP #:___________________
Subscriber is : [ ] *Patient* [ ] *Spouse* [ ] *Father* ___________ [ ] *Mother* ________

PLEASE SIGN BELOW:

I authorize the release of any medical information necessary to process claims for services rendered by the physician. I also authorize the payment of medical benefits to be issued directly to the above physician. This authorization shall be valid for the duration of any and all medical treatment this day forward.

In addition, I consent to and authorize the release of private health information to be discussed or given to my primary care physician, my referring physicians and/or any entity involved in my medical treatment. (This release is not applicable to "HIPAA")

SIGNED: ____ DATE: ____________________