BARBARA LEVY, M.D., P.S.

NAME ____ Birth Date ____________________
(Last) (First) (Middle Initial)

Relationship Status: S ___ M ___ D ___ W ___ Partner ___ Social Security Number ________________________

Address ____

City ______________________ State ______________________ Zip Code ____________________

Home # ____________________ Cell # ______________________ Work # ______________________

E-mail Address ______________________________________ **May we contact you via e-mail? YES or NO
(Circle One)

Patient's Employer _______________________________________ Occupation ______________________

Spouse/Partner or Parent Name ____________________________ Relationship to Patient ________________

Employer ____ Birthdate _______________________

PRIMARY INSURANCE:

Insurance Company ____ Phone Number ___________________

Subscriber ____ Relationship to Patient ________________

**Skip ID# & Group # if you gave your card to office staff ID# __________________________ Group # __________

SECONDARY INSURANCE:

Insurance Company ____ Phone Number ___________________

Subscriber ____ Relationship to Patient ________________

**Skip ID# & Group # if you gave your card to office staff ID# __________________________ Group # __________

Emergency Contact (other than spouse/partner)

Name __________________________________ Relationship ______________ Home # __________________

Cellular # ________________

REFERRED BY: ____

How would you like to pay for your portion of services provided? CHECK / CASH / CREDIT CARD

I hereby authorize Barbara Levy, M.D., P.S. to release any medical information necessary to process claims to the above stated insurance carrier(s). I understand this is an ongoing release of record authorization. I authorize payment of medical benefits directly to Barbara Levy, M.D., P.S. I understand that despite medical coverage I am responsible for my bill and all collection and attorney fees if collection is necessary.

Patient Signature ____ Date ______________

Parent or Legal Guardian Signature __________________________________ Date ______________
(If patient is a minor under 18 years of age)

REORDER #07-19051