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Diplomates, American Board of Internal Medicine and Infectious Disease

PERSONAL DATA

PATIENT NAME (LAST)	FIRST	MIDDLE	DATE OF BIRTH	TODAYS DATE

MARITAL STATUS S M D W OTHER	RACE	AGE	SEX MALE FEMALE

STREET ADDRESS CITY STATE ZIP	SOCIAL SECURITY NUMBER

PRIMARY PHONE	ALT PHONE	EMAIL

EMPLOYMENT DATA

EMPLOYER NAME	JOB TITLE	DEPT

EMPLOYER STREET ADDRESS CITY STATE ZIP

WORK PHONE	EXT	MAY WE LEAVE MESSAGES FOR YOU AT WORK? YES NO

RESPONSIBLE PARTY

NAME (LAST)	FIRST NAME	MIDDLE	DATE OF BIRTH	RELATIONSHIP

AGE	SEX MALE FEMALE	EMPLOYER	PRIMARY PHONE	ALT PHONE

STREET ADDRESS CITY STATE ZIP

INSURANCE DATA *PLEASE PRESENT INSURANCE CARD AND PHOTO ID AT THE TIME OF YOUR OFFICE VISIT*

INSURANCE COMPANY NAME	POLICYHOLDER NAME	POLICY /ID NUMBER	GROUP#

STREET ADDRESS	CITY	STATE	ZIP	PHONE

POLICYHOLDER DATE OF BIRTH	RELATIONSHIP TO PATIENT
	SELF SPOUSE CHILD OTHER

SECONDARY INSURANCE DATA

INSURANCE COMPANY NAME	POLICYHOLDER NAME	POLICY /ID NUMBER	GROUP#

STREET ADDRESS	CITY	STATE	ZIP	PHONE

POLICYHOLDER DATE OF BIRTH	RELATIONSHIP TO PATIENT
	SELF SPOUSE CHILD OTHER

EMERGENCY CONTACT DATA (NEAREST RELATIVE/FRIEND NOT LIVING WITH YOU)

NAME	RELATIONSHIP	HOME PHONE	WORK PHONE

NAME	RELATIONSHIP	HOME PHONE	WORK PHONE

WHOM MAY WE THANK FOR REFERRING YOU TO US?

NAME	RELATIONSHIP	PHONE	OTHER

METHOD OF PAYMENT

CHECK	CASH	CREDIT CARD	OTHER
$	$	$	$

I HEREBY AUTHORIZE PAYMENT OF INSURANCE BENEFITS OTHERWISE DUE TO ME BE MADE DIRECTLY TO THE ABOVE PHYSICIAN. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY THE INSURANCE COMPANY. I HEREBY AUTHORIZE THE ABOVE PHYSICIAN TO OBTAIN RECORDS FROM OTHER SOURCES AS MAY BE NEEDED IN THE TREATMENT OF THIS PATIENT. I HEREBY AUTHORIZE THE RELEASE OF ANY INFORMATION CONCERNING THIS PATIENT'S TREATMENT TO OTHER PHYSICIANS INVOLVED IN THE TREATMENT OF THIS PATIENT. I HEREBY AUTHORIZE THE RELEASE OF INFORMATION TO THE INSURANCE COMPANY AS NEEDED TO FILE FOR CHARGES INCURRED BY THE PATIENT.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

SIGNATURE	DATE