Patient Information

Note: Please print clearly and read before signing. Date:_____

Patient Name_____ Date of Birth:_____ Sex:_____

Marital Status_____ Social Security Number_____ Driver's License:_____

Address_____ City_____ State_____ Zip:_____

Home Phone: ( )_____ Cell Phone: ( )_____ Occupation _____

If we may contact you via email for billing or scheduling, please provide email: _____

Referring Physician_____ Phone: ( )_____May Dr. Blakeslee Contact?_____

☐ Check if same as patient; then go to next section

Responsible Party _____ Social Security #:_____

Birth date _____ Home Phone: ( )_____ Cell Phone: ( ) _____

Address_____ City_____ State_____ Zip:_____

Employer:_____ Work Phone: ( )_____ Calls Allowed?:_____

Address:_____ City:_____ State:_____ Zip: _____

Primary Medical Insurance:_____ Insured Name:_____

Address_____ City_____ State_____ Zip:_____

Relationship to Insured:_____ID#:_____ Group #:_____

Do mental health benefits need to be authorized? _____ Insurance Phone Number: ( )_____

I authorize Dr. Blakeslee to release information for payment, treatment, and health care operations. _____
Signature

PLEASE PROVIDE A COPY OF BOTH SIDES OF INSURANCE CARD

Secondary Medical Insurance:_____ Insured Name:_____

Address_____ City_____ State_____ Zip:_____

Relationship to Insured:_____ID#:_____ Group #:_____

Do mental health benefits need to be authorized? _____ Insurance Phone Number: ( )_____

I authorize Dr. Blakeslee to release information for payment, treatment, and health care operations. _____
Signature

PLEASE PROVIDE A COPY OF BOTH SIDES OF INSURANCE CARD

Person who does not live with you to contact if we are unable to reach you:_____

Phone: ( ) _____ Address:_____