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Patient's Name: _____
Last First Middle

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Marital Status (circle one): S M D W

Social Security No.: _____ Date of Birth: _____ Age: _____

Email Address: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

Spouse's Name: _____
Last First Middle

Social Security No.: _____ Date of Birth: _____ Age: _____

Email Address: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

Pharmacy 1st Choice _____ Pharmacy 2nd Choice _____

If mail order pharmacy, Pharmacy ID number: _____

Person to notify in case of emergency (*not at same address*): Name: _____

Phone Number (home): _____ Relationship: _____

Doctor you are seeing: _____

Referred to the Doctor by: _____

INSURANCE INFORMATION

Primary Insurance: _____ Secondary Insurance: _____

Please give your insurance cards to the receptionist so we may keep a copy on file.

Policy Holder: Name: _____ Relationship to you: Self Spouse Child

Social Security No.: _____ Date of Birth: _____

Place of Employment: _____

I hereby authorize New Milford Medical Group to furnish all information to insurance carriers and other health care providers concerning my illness and treatments and assign all payments for medical services rendered to myself or my dependents to New Milford Medical Group, LLC. I understand that I am responsible for any amount not covered by insurance. This information includes Protected Health Information.

Signature: _____ Date: _____