11 Old Park Lane
New Milford, CT 06776
Phone: 860-355-1149
Fax: 860-355-5957
www.nmmedicalgroup.com

PRIMARY CARE
Harold J. Kamm, MD
Jeffrey C. Tyler, MD
Doreen M. Konik, MD
Christian Leonardi, DO
Jonathan D. Beck, MD

CARDIOLOGY
Michael G. Levine, MD, FACC
William Cicio, MD, FACC

PHYSICIANS ASSISTANTS
Dimitri Ghecas, MBA, PA-C, PT
Amanda Madkour, MS, PA-C

Patient's Name:____
Last First Middle

Address:____

City:____________________ State:______________ Zip Code:________________

Preferred Contact Phone:______________ **Is this Home or Cell ?** Marital Status (circle one): S M D W

Race (circle one): Caucasian/White African-American Asian Hispanic Indian Multiracial Other ____________

Primary Language: English Spanish Other ____________ Ethnicity: Hispanic/Latino Not Hispanic/Latino

Social Security No.:____________________ Date of Birth: ________________ Age:______

Email Address:____________________ Home/Cell Phone (secondary contact number):______________

Employer:________________________________ Work Phone:______________

Spouse's Name:____
Last First Middle

Date of Birth: ________________ Age:______

Email Address:________________________________ Cell Phone:______________

Employer:________________________________ Work Phone:______________

Pharmacy 1st Choice ____________________________ Location ________________

Pharmacy 2nd Choice____________________________Location________________

If mail order pharmacy, Pharmacy ID number: ________________________________

Person to notify in case of emergency:____________________Relationship:______________

Home Phone Number: ________________ Cell or Alternate Number:________________

GUARANTOR / RESPONSIBLE PARTY INFORMATION - If the guarantor is different than the patient, please complete and sign:

Guarantor Name____ DOB: ____________
First M.I. Last

Address: ____
Street/PO Box City State Zip

Home Phone______________ Cell Phone ______________ Soc Sec # ____________

Relationship to Patient ______________ E-mail Address________________________

As the responsible party, I understand that I am responsible for payment of any outstanding charges on this account.

Signature____ Date ____________

INSURANCE INFORMATION

PRIMARY INSURANCE::____
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Policy Holder: Name:____________________________________ Relationship to you: Self Spouse Parent

Social Security No.:______________________ Date of Birth:______________________________

Place of Employment:____

SECONDARY INSURANCE:____

Policy Holder: Name:____________________________________ Relationship to you: Self Spouse Parent

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: ____________________________