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PRIMARY CARE
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CARDIOLOGY
Michael G. Levine, MD, FACC
Donald I. Katz, MD, FACC

PHYSICIANS ASSISTANTS
Caitrin Olson, PA-C
Kara Clark, PA-C
Mae Janiga, PA-C

Patient's Name:____
Last First Middle

Address:____

City:______________________ State:______________ Zip Code:________________

Home Phone#:__________ Cell Phone#: ____________ Marital Status (circle one): S M D W

Social Security No.:___________ Date of Birth: ________ Email Address: __________________

Employer:____________________________ Work Phone:______________________

Emergency Contact: ___________________ **Relationship:** ______________ **Phone#**________

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

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

PRIMARY INSURANCE

Insurance Carrier Name: ___________________ ID#:____________ Group#:____________

Policyholder Name__________________ DOB:___________ Soc Sec #_______________

Home Address: ________________________________ Email Address: _______________

Home Phone_____________ Cell Phone ________________ Relationship to Patient:__________

SECONDARY INSURANCE

Insurance Carrier Name: ___________________ ID#:____________ Group#:____________

Policyholder Name__________________ DOB:___________ Soc Sec #_______________

Home Address: ________________________________ Email Address: _______________

Home Phone_____________ Cell Phone ________________ Relationship to Patient:__________

Pharmacy 1st Choice ____________________________ Location ___________________

Pharmacy 2nd Choice____________________________Location___________________

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 of Patient or Authorized Person:______________________________ **Date:** ________

Printed Name:__________________ **Relationship of Authorized Person to Patient:**______________