BRUCE E. FREEDMAN
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# PATIENT INFORMATION FORM:

## GENERAL INFORMATION

SS#: __ __ __ - __ __ - __ __ __ __ Patient's Name: ________________________________

Permanent Address: ________________________________ APT# __________

City: ______________________ State: ____________ Zip: __________

Local Address: ________________________________ APT# __________

City: ______________________ State: ____________ Zip: __________

Date of Birth: __ __ / __ __ / __ __ __ __ Sex: ( M / F ) Marital Status: ( S / M / W / D )

Race: ☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian ☐ Other__________________

Ethnicity:________________ ☐ Prefer not to answer Language: ________________

Phone #: ( __ __ __ ) __ __ __ - __ __ __ __ Work Phone #: ( __ __ __ ) __ __ __ - __ __ __ __

Other Phone #: ( __ __ __ ) __ __ __ - __ __ __ __

Email:________________________________________________

Primary Care Physician: ____________________ Phone #: ( __ __ __ ) __ __ __ - __ __ __ __

E-Med Consent: (signature) ________________________________________

May we download your medication history from your Pharmacy: ☐ Yes ☐ No

Pharmacy Name: ________________ Pharmacy Phone #: ( __ __ __ ) __ __ __ - __ __ __ __

Pharmacy Address: ________________________________________________

## PRIMARY INSURANCE

Ins. Co. Name:____________________

Policy #:__________ Group #:________

Relation to Patient: ________________

Insured's Name: __________________

Insured's DOB: ___ / ___ / ______ M / F

Insured's Employer:________________

Insured's SS#: __ __ __ - __ __ - __ __ __ __

## SECONDARY INSURANCE

Ins. Co. Name:____________________

Policy #:__________ Group #:________

Relation to Patient: ________________

Insured's Name: __________________

Insured's DOB: ___ / ___ / ______ M / F

Insured's Employer:________________

Insured's SS#: __ __ __ - __ __ - __ __ __ __

I HEREBY AUTHORIZE PAYMENT OF INSURANCE DIRECTLY TO PHYSICIAN. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR CHARGES NOT COVERED UNDER THIS AUTHORIZATION. I HEREBY AUTHORIZE BRUCE FREEDMAN, M.D., F.A.C.S. TO RELEASE AND/OR OBTAIN ANY MEDICAL INFORMATION NECESSARY IN THE COURSE OF MY TREATMENT.

Signature of responsible party or guardian: ________________________________