PATIENT INFORMATION FORM

IN ORDER TO SERVE YOU PROPERLY WE NEED THE FOLLOWING INFORMATION.
ALL INFORMATION IS STRICTLY CONFIDENTIAL.

TODAYS DATE: _____ REFERRED BY: _____

PATIENT'S NAME_____**BIRTHDATE**_____
(FIRST) (M.I.) (LAST)

SOCIAL SECURITY#_____**MARITAL STATUS**_____**SEX: M F**

ADDRESS_____
(STREET) (CITY) (ZIP)

HOME PHONE_____**CELL PHONE**_____

EMPLOYER_____**WORK PHONE**_____

EMAIL ADDRESS_____

EMERGENCY CONTACT_____ PHONE:_____

- PLEASE PROVIDE THE BEST NUMBER TO REACH YOU TO GIVE ANY CLINICAL RESULTS _____
- MAY WE LEAVE A VOICEMAIL WITH RESULTS OR CLINICAL INSTRUCTIONS? _____

- **I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES FOR SERVICES TO ME, INCLUDING THE BALANCE REMAINING AFTER PAYMENT OF POSSIBLE INSURANCE BENEFITS.**

- **ASSIGNMENT OF BENEFITS – I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO:**
  _____ALEXANDRA DRESEL, M.D.

- **RELEASE OF INFORMATION – I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS AND I ALSO AUTHORIZE DR. ALEXANDRA DRESEL TO OBTAIN FROM ANY HOSPITAL, PHYSICIAN OR INDIVIDUAL INSTITUTION ANY MEDICAL INFORMATION FROM THEIR MEDICAL RECORDS PERTINENT TO MY MEDICAL CARE.**

SIGNED_____DATE_____
(PATIENT OR PARENT IF MINOR)