

John Okun, M.D. / Robert Maddalon, M.D. / Peter Lopez, M.D. / Steven Page, MD

Please circle the name of which doctor you will be seeing.

Patient Name _____ Age _____ Sex _____ Birthdate _____

Single Married Widowed Divorced Separated (Circle One)

Mailing Address: _____ Phone _____

Permanent Address: _____ Phone _____

_____ Soc. Sec. # Guarantor _____

Social Security No. _____ Occupation _____

Employer's Name _____

Employer's Address: _____ Phone _____

Spouse's name _____ Employed by _____

Employer's Address _____ Phone _____

In Case of an Emergency, Contact _____ Phone _____

If Applicable: Auto Injury Date of Injury _____ Primary Care Physician _____
DD/MM/YY

If Minor:

Mother's Name _____ Employed by _____

Address _____ Phone _____

MEDICARE OR GROUP MEDICAL INSURANCE

Primary Care Doctor _____ Policy holder's name _____

Insurance Co. _____ Policy holder's Birthdate _____

Have you had any type of surgery in the last 90 days: Yes No

SECONDARY/SUPPLEMENT INS./THIRD PARTY INS.

Patient's Name _____ Policy holder's name _____

Insurance Co. _____

Date _____
Signature of Patient or Responsible Party

PLEASE CIRCLE:

CASH

MC – VISA - DISCOVER

PLEAE NOTE: It is our policy to accept Medicare and certain HMO insurance coverages. Otherwise it is not our policy to accept assignment on regular medical insurance. We will be happy to work with you to file you claims, as payments are being made by you on the account.