MICHELLE ENDICOTT, DO

PATIENT INFORMATION *(Please Print)* Today's Date ________/_________/_________

Name____SS#______________________________
First *M.I.* *Last*

Mailing Address____
City *State* *Zip*

Home Phone_________________________Work_______________________Cell_____________________
Area Code Area Code Area Code

Date of Birth_________/__________/___________ Age___________ Sex_________ Marital Status_______________

PARENT OR RESPONSIBLE PARTY (*if different from patient*)

Name____ Date of Birth________/________/________
First *M.I.* *Last*

Address____
City *State* *Zip*

Home Phone____________________________Work________________________Cell________________________
Area Code *Area Code* *Area Code*

Are you employed? ☐ Yes ☐ No

If yes, where are you employed?____

Referred by: _____________________________________Primary Care Physician:_______________________________

INSURANCE INFORMATION (*Please present insurance card at time of check in.)*

Primary Ins. Name________________________________

Name of Insured________________________________

Insured's Date of Birth _________/____________/____________

Insured's S.S. #________________________________

Insured's ID#________________________________

Group#________________________________

Employer________________________________

Employer Phone________________________________
Area Code

Relationship to patient__________________________

Secondary Ins. Name________________________________

Name of Insured________________________________

Insured's Date of Birth ___________/____________/______________

Insured's S.S. #________________________________

Insured's ID#________________________________

Group#________________________________

Employer________________________________

Employer Phone________________________________
Area Code

Relationship to patient__________________________

Pharmacy of choice:____Phone:_________________________________

Other family members that are patients:____

In case of Emergency, who should be notified?____________________________________Phone:__________________________

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician. I understand that payment is required for all services at the time they are rendered unless I am in a plan that the physician participates, in which case applicable copayments and deductibles will be collected. My signature signifies my understanding and willingness to comply with this policy.

Patient or Responsible
Party Signature____ Date_______/________/_________
(Parent must sign if patient is a minor)