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INFORMATION REQUIRED FOR CASE HISTORY FILE Date: _____

First Name: _____ Middle Name: _____ Last Name: _____
Is this your legal name? Yes ☐ No ☐ If not, what is? _____
Address: _____
City: _____ State: _____ Zip: _____ Rent ☐ Own ☐
Home Phone: _____ Cell Phone: _____ SSN: _____
Birthdate: _____ Age: _____ Male ☐ Female ☐

Employment Status: Full Time ☐ Part Time ☐ Retired ☐ Unemployed ☐ Student ☐
Employer: _____ Occupation: _____
Address: _____ City: _____ State: _____ Zip: _____
Work Phone: _____ Driver's License #: _____

Marital Status: Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐
Spouse's First Name: _____ Middle Name: _____ Last Name: _____
SSN: _____ Birthdate: _____ Driver's License #: _____
Employer: _____ Occupation: _____ Work Phone: _____
Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact: _____ Relationship: _____ Phone #: _____
Address: _____ City: _____ State: _____ Zip: _____
Nearest Relative (not living together): _____ Phone #: _____
Address: _____ City: _____ State: _____ Zip: _____

Primary Care Physician: _____ Phone #: _____
Referred by: _____ Phone #: _____

Do you have medical insurance? Yes ☐ No ☐

Primary Insurance Co: _____	Secondary Insurance Co: _____
Address: _____	Address: _____
_____	_____
Member #: _____	Member #: _____
Group #: _____	Group #: _____
Insured's Name: _____	Insured's Name: _____

PLEASE GIVE YOUR MEDICARE OR OTHER INSURANCE CARD TO THE RECEPTIONIST.

RELEASE OF INFORMATION / ASSIGNMENT OF BENEFITS

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Jeffrey A. Punim or insurance company to release any information required to process my claims.

Patient Signature: _____ Date: _____
(or Parent/Guardian Signature)