

PATIENT INFORMATION

Patient Name: _____
Address: _____

Home Phone: (____) _____ Cell/Pager#: (____) _____

SS#: _____ DOB: _____

Gender: Male Female Age: _____

Marital Status: Single Married Divorced Widowed

Preferred/Nick Name: _____

Referring Physician: _____

Employment Status: Full time Part time Not Employed

Student Status: Non-Student Full-Time Part-Time

Employer: _____

Address: _____

Phone: _____ Ext.: _____

Responsible Party: _____ Phone (____) _____

Would you like information on Advanced Directives? ___Yes ___No

How did you learn of our practice?

Prior Patient _____ Television _____ Yellow Pages _____

Seminar _____ Website _____ Newspaper _____

Magazine _____ Radio _____ Dr Mendelsohn's Book _____

Who may we thank for your referral? _____

Patient Doctor Friend Relative Other

Drug Allergies: _____ none

Emergency Contact: Name: _____ Relationship _____

Phone: (____) _____

Email Address: _____

Would you like to receive our monthly newsletter via email? ___yes ___no

Best place to reach me by phone: Home Work Cell Any

DO NOT contact me by phone: Home Work Cell Any

Are there any special occasions or dates planned in your future? ___yes ___no

If so, please explain: _____

All fees are payable at the time of your service. All surgeries must be paid for, in full, 14 days prior to service. Dr. Mendelsohn does not participate with any insurance carriers. Our office will only file claims with your insurance carrier when procedures are deemed "medically necessary." When applicable I authorize Dr. Mendelsohn to furnish to my insurance carrier, all information that the insurance company may request. Because Dr. Mendelsohn does not participate with any insurance companies all procedures must be pre-paid and any reimbursement from your insurance company will be sent directly to you. I understand that, ultimately, I am responsible for all fees, regardless of insurance coverage.

Signature: _____ **Date:** _____

(Legal guardian, if minor)