Dr. Jeffrey D. Gaber & Associates, PA

PATIENT INFORMATION SHEET – Please Print – Complete All Information

SOCIAL SECURITY # ___________ - _______ - ___________ TODAY'S DATE: __________________________

LAST NAME: ___________________________________ SUFFIX: _________ FIRST NAME: ____________________________ MI: _______

ADDRRESS: ____ CITY: _________________________ STATE: _____ ZIP:__________

HOME PHONE: (______) ____________________________ WORK PHONE: (______) ___________________________ EXT: _____________

DATE OF BIRTH: ________________ MARRIED: ______ SINGLE: ____ WIDOWED: ___ DIVORCED: ___ SEX: ___MALE ____ FEMALE

DRIVER'S LICENSE #: ___________________________________ EMERGENCY CONTACT: _________________ PHONE: (___) __________

CELL PHONE/PAGER: (___) __________ FOR MINORS: MOM'S WORK PHONE: (_____) __________ DAD'S WORK PHONE: (___) ________

PHARMACY: ___________________________________ ADDRESS: ___________________________________ PHONE: (_____) __________

EMPLOYER: ____ ADDRESS: ____

PHONE: (___) ______ EMPLOYMENT STATUS: __FULL-TIME __PART-TIME ___UNEMPLOYED ___STUDENT ___HOUSEWIFE/HUSBAND

REFERRED BY: DOCTOR _______________________________________ ADDRESS ____

FRIEND _____________________ OTHER PATIENT _________________ INSURANCE CO. _______________ OTHER _______________

PRIMARY INSURANCE COVERAGE

RESPONSIBLE PARTY FOR BALANCE: _______ SELF _______ PARENT _______ OTHER (explain) ______________________________

PRIMARY INSURANCE: ____________________________________ CLAIMS ADDRESS: ____

CITY: ____ STATE: ______ ZIP CODE: ______________ PHONE: (_____) __________

CO-PAY: $_____________ SUBSCRIBER (PERSON WHO OWNS THE INSURANCE): ____

PATIENT'S RELATIONSHIP TO SUBSCRIBER: _______________________ SUBSCRIBER'S SOCIAL SECURITY #:________ - _____ - ________

SUBSCRIBER'S ADDRESS: ______________________________________ CITY__________________ STATE____ ZIP CODE____________

HOME PHONE: (____)____________ WORK PHNE: (_____) ___________ BIRTH DATE: _______________ SEX: _____MALE _____ FEMALE

SUBSCRIBER'S EMPLOYER: _____________________ ADDRESS: __________________ CITY: ___________ STATE: ____ ZIP CODE:______

INSURANCE POLICY ID #: _________________________ GROUP #: ____________ EFFECTIVE DATE OF INSURANCE: __________ _____

SECONDARY INSURANCE COVERAGE

PRIMARY INSURANCE: ___________________________________ CLAIMS ADDRESS: ____

CITY: ____ STATE: _________ ZIP CODE: ________________ PHONE: (_____) ___________

CO-PAY: $______________ SUBSCRIBER (PERSON WHO OWNS THE INSURANCE): ____

PATIENT'S RELATIONSHIP TO SUBSCRIBER: _________________________ SUBSCRIBER'S SOCIAL SECURITY #:________ - ___ - ________

SUBSCRIBER'S ADDRESS: _____________________________________ CITY: ____________________ STATE: _____ Z IP CODE: __________

HOME PHONE: (___) ___________ WORK PHONE: (___) ______________ BIRTH DATE: ________________ SEX: ____MALE _____ FEMALE

SUBSCRIBER'S EMPLOYER: ___________________ ADDRESS: ___________________ CITY: _____________ STATE: ____ ZIP CODE:______

INSURANCE POLICY ID #: _____________________ GROUP #: __________________ EFFECTIVE DATE OF INSURANCE: ________________