## DOYLESTOWN THYROID AND ENDOCRINE ASSOCIATES

Date of visit:________________

Patient's name:________________________ DOB____________

Address: ______________________________________________________________________

Home Phone: _____________ Cell Phone: ______________ Work Phone: ______________

Referred by: ____________________ Family Doctor & phone: ________________________

Gender: M or F Marital Status: Single Married Divorced/Separated Widowed

Emergency contact name and phone #: ____________________________________________

Relationship ____________ Guardian name (if required) _____________________________

Medical Insurance Info: ______________________ ID#: ______________________________

Group Number: ___________________ Subscriber's name: ___________________________

Subscriber's date of birth: _______________ Relationship to subscriber __________________

Secondary Insurance: ___________________________ ID#: ____________________________

Group Number: _____________ Subscriber's name: _______________________________

Email: ______________________________________

Pharmacy name and address: _____________________________________________________

Pharmacy phone: _____________________

*I hereby authorize Doylestown Thyroid & Endocrine Associates to release any information necessary to insurance carriers to process claims. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance remaining after submission to my insurance. I have received and reviewed the practice's* ***Financial Policies and Procedures****.*

Signature of Patient or Responsible Party: __________________________________________

*By signing this form, I am acknowledging that Doylestown Thyroid and Endocrine Associates provided to me information about its Notice of Privacy Practices. This notice provides information about how we may use and disclose your protected health information. I have received and reviewed this practice's* ***Notice of Privacy Practices.***

Signature of Patient or Responsible Party: __________________________________________