KAUFMAN & ZINSMEISTER, M.D., P.A.

2900 LINDEN LANE SUITE 200 ♥ SILVER SPRING, MARYLAND 20910 ♥ (301) 587-7040

PATIENT INFORMATION

In order to serve you properly, it is important to have the following information.

Please print. All information will be confidential.

General Information

Today's Date: _____ (mm/dd/yy) Account No.: _____

First Name: _____ MI: _____ Last Name: _____

Date of Birth: _____ Sex: _____ Age: _____ SSN: _____-_____-_____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Address (if different): _____

City: _____ State: _____ Zip Code: _____

Home Phone: ( ) _____-_____ Work Phone: ( ) _____-_____

Single ☐ Married ☐ Divorced ☐ Widowed ☐ Retired ☐ Student: PT ☐ FT ☐

Employer's Name: _____ Position: _____

Employer's Address: _____

City: _____ State: _____ Zip Code: _____

Emergency Contact

Contact 1: _____ Relationship to Patient: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: ( ) _____-_____ Work Phone: ( ) _____-_____

Contact 2: _____ Relationship to Patient: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: ( ) _____-_____ Work Phone: ( ) _____-_____

Referring Doctor & Primary Care Doctor

Referring Doctor: _____ Phone Number: ( ) _____-_____

Address: _____

City: _____ State: _____ Zip Code: _____

Primary Care Doctor: _____ Phone Number: ( ) _____-_____
(if different)

Address: _____

City: _____ State: _____ Zip Code: _____

Patient Name: _____ **Account No:** _____

Responsible Party (If different from patient)

Name: _____ Relationship to Patient: _____
SSN: ____-___-___ Date of Birth: _____ Employer: _____
Mailing Address: _____
City: _____ State: _____ Zip Code: _____
Home Address (if different): _____
City: _____ State: _____ Zip Code: _____
Phone #: Home: ( ) _____ -_____ Cell: ( ) _____ -_____ Work: ( ) _____ -_____
Preferred Method of Payment: Cash ☐ Check ☐ Visa ☐ MC ☐ Discover ☐ AmEx ☐

Primary Insurance

Insurance Company: _____ HMO ☐ PPO ☐ Co-Pay: $_____
ID/Policy Number: _____ Group/Code: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Subscriber's Name: _____ Date of Birth: _____ Sex: _____
Relationship to Patient: _____ Date Effective: _____
SSN: _____-_____-_____ Employer's Name: _____
Subscriber's Address:_____
City: _____ State: _____ Zip Code: _____
Home Phone: ( ) _____ -_____ Work Phone: ( ) _____ -_____

Secondary Insurance

Insurance Company: _____ HMO ☐ PPO ☐ Co-Pay: $_____
ID/Policy Number: _____ Group/Code: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Subscriber's Name: _____ Date of Birth: _____ Sex: _____
Relationship to Patient: _____ Date Effective: _____
SSN: _____-_____-_____ Employer's Name: _____
Subscriber's Address:_____
City: _____ State: _____ Zip Code: _____
Home Phone: ( ) _____ -_____ Work Phone: ( ) _____ -_____