ALAN M. FREEDMAN, M.D.
UROLOGY

NEW PATIENT INFORMATION RECORD

PATIENT

Date (mm/dd/yyyy): ____________________ Soc. Sec. Number: ________ – _______ – __________

Name: ______________________________ (LAST FIRST MI) Birthdate: ______________ Age: __________

City: ______________ State: __________

Street: ______________________________ Drivers Lic. No.: ______________ Sex: __________

Zip: __________ Phone: (____) _____ – ________ Marital Status: ______________________

PRIMARY INSURANCE COMPANY

Carrier: ______________________________ Phone: (____) _____ – ________

Street ______________________________ Name of Insured: ______________________

City/State: ______________________________ Soc. Sec. Number: ________ – _______ – __________

Zip: ______________________________ Group No.: ______________ Copay: $ __________

SECONDARY INSURANCE COMPANY

Carrier: ______________________________ Phone: (____) _____ – ________

Street ______________________________ Name of Insured: ______________________

City/State: ______________________________ Soc. Sec. Number: ________ – _______ – __________

Zip: ______________________________ Group No.: ______________ Copay: $ __________

RESPONSIBLE PARTY (self if 18 or over)

Name: ______________________________ Soc. Sec. Number: ________ – _______ – __________

Street: ______________________________ City: ______________ State: __________

Zip: __________ Phone: (____) _____ – ________ Relationship: ______________________

EMPLOYED BY

Company Name: ______________________ Occupation: ______________ Phone: (____) _____ – ________

Street: ______________________________ City/State: ______________________ Zip: __________

RELATIVE OR FRIEND NOT LIVING WITH YOU

Name: ______________________________ Phone: (____) _____ – ________

REFERRED BY

(Check One:) Doctor Friend Relative Insurance Yellow Pages

Name: ______________________________ City: ______________________

Street: ______________________________ State: ______________________

Zip: __________ Phone: (____) _____ – ________

SPOUSE

Name: ______________________________ Employed By: ______________________

Work Phone: (____) _____ – ________

OFFICE USE ONLY

Patient's or Authorized Person's Signature

I authorize the release of any medical information necessary to process this claim and payment of medical benefits to undersigned physician

Signed ______________________________ **Date** ______________