

PATIENT INFORMATION FORM

**IN ORDER TO SERVE YOU PROPERLY WE NEED THE FOLLOWING INFORMATION.
ALL INFORMATION IS STRICTLY CONFIDENTIAL.**

TODAYS DATE: _____ REFERRED BY: _____

PATIENT'S NAME _____ BIRTHDATE _____
(FIRST) (M.I.) (LAST)

SOCIAL SECURITY# _____ MARITAL STATUS _____ SEX: M F

ADDRESS _____
(STREET) (CITY) (ZIP)

HOME PHONE _____ CELL PHONE _____

EMPLOYER _____ WORK PHONE _____

EMAIL ADDRESS _____

EMERGENCY CONTACT _____ PHONE: _____

- PLEASE PROVIDE THE BEST NUMBER TO REACH YOU TO GIVE ANY CLINICAL RESULTS _____
- MAY WE LEAVE A VOICEMAIL WITH RESULTS OR CLINICAL INSTRUCTIONS? _____

- **I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES FOR SERVICES TO ME, INCLUDING THE BALANCE REMAINING AFTER PAYMENT OF POSSIBLE INSURANCE BENEFITS.**
- **ASSIGNMENT OF BENEFITS – I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO:**
 ALEXANDRA DRESEL, M.D.
- **RELEASE OF INFORMATION – I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS AND I ALSO AUTHORIZE DR. ALEXANDRA DRESEL TO OBTAIN FROM ANY HOSPITAL, PHYSICIAN OR INDIVIDUAL INSTITUTION ANY MEDICAL INFORMATION FROM THEIR MEDICAL RECORDS PERTINENT TO MY MEDICAL CARE.**

SIGNED _____ DATE _____
(PATIENT OR PARENT IF MINOR)