Welcome Please complete this form completely in ink. This information will remain confidential.

# Patient Information

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Last name: Sherman | First name: Florence | | | Initial: O. | Date of birth: 05/29/1957 | Home phone: 312-555-1217 | | | |
| **Address:**  6111 N. Lincoln Avenue | | | | | **Marital Status: (check appropriate box)**  **S** ⌧ **M D W** | | | Sex **M** ⌧ **F** | |
| **City:**  Chicago | | **State:**  IL | **Zip:**  60608-3173 | | **Social Security Number:**  669-35-2244 | | | | |
| **Patient’s employer: (If student, name of school.)**  retired | | | | | **Employment address:**  ------  **Business phone:** | | | | |
| **Bill to:**  self | | | | | **Relationship:**  ------ | | | | |
| **Address:**  same | | | | | **City:** | | **State:** | | **Zip:** |
| NOTIFY IN CASE OF EMERGENCY | | | | | | | | | |
| **Name:**  Tony Sherman | | | | | **Relationship:**  Husband | | | | |
| **Address:**  same | | | | | **Phone:**  home: 312-555-1217 | | | | |
| **City:**  same | | **State:**  -- | **Zip:**  ---- | |  | | | | |
| **INSURANCE INFORMATION** | | | | | | | | | |
| **Primary insurance company:**  Medicare | | | | | **Secondary insurance company:**  ------------- | | | | |
| **Policyholder’s name: DOB:**  same 05/29/1957 | | | | | **Policyholder’s name: DOB:**  ------------ | | | | |
| **Policy #: Group #:**  669-35-2244B | | | | | **Policy #: Group #:**  ----------- | | | | |
| OTHER INFORMATION | | | | | | | | | |
| **Reason for visit:**  menopausal problems | | | | | **Name of referring physician:**  ------------ | | | | |
| Florence Sherman Patient’s signature/Parent or guardian’s signature | | | | | 11/15/20--  **Today’s date** | | | | |

###### WP