INFECTIOUS DISEASE CONSULTANTS

Patient Information

Name:_____ Date of Birth: _____

Address:_____ **City:**_____ **State:**_____ **Zip:** _____

Home Phone:_____ Cell Phone: _____ Email: _____

Please circle all that apply: Male/Female Employed/Retired/Other Married/Single/Other

Companion/Relative Name:_____ Phone: _____

Primary Doctor:_____ Phone: _____

Referring Physician:_____ Phone: _____

Referring Physician Address: _____

Would you like your results sent to your family doctor? **Y/N** (circle one)

How did you hear about us? Referred By: Doctor: _____ Friend: _____

Insurance Information - Please provide Insurance card(s)with this completed form

Policy Holder's Name: _____ Policy Holder's Date of Birth: _____

Address: _____ City: _____ State: ____ Zip: _____

Insurance Company: _____ insured's ID#: _____

Policy Group ID#:_____ Social Security #: _____

Insurance Plan Name/Program: _____ Policy Holders Relationship: _____

Do you have Medicare Coverage? **Y/N** (circle one) (self, spouse, child, other)

Policy Holder's Employer Name: _____ Phone: _____

Secondary Insurance Information

Policy Holder's Name: _____ Policy Holder's Date of Birth: _____

Address:_____ City: _____ State: Zip: _____

Insurance Company:_____ Insured ID#: _____

Policy Group ID#:_____ Social Security #: _____

Insurance Plan Name/Program:_____ Policy Holders Relationship: _____

Do you have Medicare Coverage? **Y/N** (circle one) (self, spouse, child, other)

Policy Holder's Employer Name: _____ Phone: _____