DENNIS GLICK, MD

Patient Information Sheet

Medical Record# _____ Date of 1st appt. _____

Last Name_____ First Name_____ MI_____

Address_____ Unit/Apt# _____ Home Phone_____

City_____ State_____ Zip_____ Work Phone_____ ext_____

Patient Age _____ Date of Birth_____ Male/Female Cell # _____ (best number? Y N)

Meaningful Use Criteria for Health Care (Circle one in each category or circle Decline to Answer)
Circle One: Patient's Race: African American / Asian / Caucasian / Biracial / Hispanic / Decline to Answer
Circle One: Patient's Ethnicity: Hispanic or Latino / Not Hispanic or Latino / Decline to Answer

Guarantor/Responsible Party _____ Home Phone_____

Address _____ Work Phone_____

Emergency Contact_____ Relationship to Patient _____ Phone # _____

INSURANCE INFORMATION

Primary Insurance: _____ Phone # _____

Member ID# _____ Group #_____ Plan #_____

Subscriber/Policyholder's Name: _____ DOB: _____

Social Security # _____ (if required for billing purposes) Employer:_____

Secondary Insurance: _____ Member ID# _____ Group# _____

Policyholder's Full Name:_____ Policyholder Date of Birth:_____ Employer:_____

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INSURANCE BENEFIT SUMMARY (For Administrative Use)

Primary Ins: _____ Effective Date: _____

Deductible: _____Met For Current Year: _____

Therapy Co-pay or Coinsurance: _____ Medication Co-pay (CPT 99213/4 only): _____

Pre-cert Requirements: _____

Limit on # of visits: _____ Auth #_____ # of visits authorized: _____

Effective Date of Auth _____ Expiration Date of Auth _____ Provider: _____

Claims Address: _____ Spoke with: _____ Admin Name and Date: _____