PATIENT INFORMATION

Patient Name: Age: Date of Birth:

Street Address:

City: State: Zip Code:

Phone #'s: Home: Wk: Cell:

Social Security #: Marital Status: M__ S__ D__ W__

Email Address:

What form of communication may we use to contact you?

Email____ Text____ Cell____ Home____ Work____

Employer: Position:

Employer Phone:

Employer Address:

Is patient a minor? Y___ N___ If so, name of responsible party:

Responsible party's Address: Phone:

Relationship to patient:

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Person(s) we may contact in case of an emergency:

Name: Phone #1: Phone #2:

Relationship to patient: Home____Cell____Work____ Home____Cell____Work____

Name: Phone #1: Phone #2:

Relationship to patient: Home____Cell____Work____ Home____Cell____Work____

Patient or Responsible Party Signature Date

Who may we thank for referring you to us?____

Medicare Eligible Patients

I, ____, understand that Dr. Howard J. Lang & Dr. Derek H. Lang have "opted out" of Medicare, effective November 1, 2004. I also understand that I will be responsible for payment of all charges incurred after the above date, including any laboratory work up (blood studies). I further understand that these charges will not be sent to Medicare (no reimbursement) nor to my secondary insurance company (no reimbursement) because Medicare will not pay for any of my services.

I agree to be responsible **for all expenses** incurred.

Patient Name:______________________________________

Medicare #:____

Date:____