Lisa L. Savage, M.D., P.A.

PATIENT INFORMATION SHEET

(Please leave no blank spaces.)

Patient's Full Name _____ Age _____ DOB _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Married___Single___ Divorced___ Separated___ Widowed___

Social Security # _____ Driver's License # _____State _____

Patient's Employer _____ Work Phone _____

Address _____ City _____ State _____ Zip _____

Occupation _____ Fulltime Student? YES NO Cell Phone / Pgr # _____

Spouse _____ Social Security # _____

Spouse's Employer _____ Work Phone _____

Family Physician _____ Phone # _____ Referred by _____

In case of emergency, contact (other than spouse): _____ Phone # _____

Relationship to patient _____ Pharmacy Name & Phone # _____

INSURANCE INFORMATION

Name of Insurance Co. – Primary Coverage

ID# _____

Group # _____

Subscriber _____

Subscriber's Employer _____

Subscriber's DOB _____

Relationship to Patient _____

Other Insurance? YES NO (If yes, list below.)

ID# _____

Group # _____

Subscriber _____

Subscriber's Employer _____

Subscriber's DOB _____

Relationship to Patient _____

PERSON RESPONSIBLE FOR BILL IF PATIENT IS A MINOR CHILD:

Name _____ Address _____

City _____ State _____ Zip _____

Driver's License # _____

PLEASE READ CAREFULLY BEFORE SIGNING: I understand that I am responsible for all the charges accumulated while under Dr. Savage's care. Full payment is due at the time of service unless other arrangements are made in advance.

X _____ Date: _____