TARRYTOWN FUNCTIONAL MEDICINE

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PLEASE PRINT ABOVE LINE

*_____

FIRST NAME LAST NAME INITIAL E-MAIL ADDRESS

*_____

ADDRESS APT# CITY STATE ZIP CODE

*_____

HOME PHONE# WORK PHONE# SOC SEC # MARRIED YES__ NO__ SEX M__F__ BIRTHDATE

_____

EMPLOYER NAME EMPLOYER ADDRESS YOUR OCCUPATION **AGE**_____

INSURANCE #1

_____

INSURANCE NAME ADDRESS TELEPHONE#

_____

INSURANCE ID# CATEGORY# GROUP#

_____

INSURED NAME INSURED BIRTHDATE RELATION TO PATIENT

_____

INSURED EMPLOYER ADDRESS WORK PHONE

INSURANCE #2

_____

INSURANCE NAME ADDRESS TELEPHONE#

_____

INSURANCE ID# CATEGORY# GROUP#

_____

INSURED NAME INSURED BIRTHDATE RELATION TO PATIENT

_____

INSURED EMPLOYER ADDRESS WORK PHONE

_____

PHARMACY NAME ADDRESS TELEPHONE

_____

IN CASE OF EMERGENCY NOTIFY RELATION TO PATIENT HOME PHONE WORK PHONE

_____

ADDRESS APT# CITY STATE ZIP CODE

_____

REFERRED BY **TELEPHONE#**

_____

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICAL OR MEDICARE BENEFITS BE MADE ON MY BEHALF TO DR. JILL FETELL FOR ANY SERVICES FURNISHED TO ME BY THAT PHYSICIAN. I AUTHIRIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE IT TO MY INSURANCE COMPANY AS NEEDED TO DETERMINE BENEFITS PAYABLE FOR RELATED SERVICES.

PATIENT'S SIGNATURE_____

DATE_____

INSURANCE CHECKING INFORMATION

AMOUNT OF DEDUCTIBLE_____
INSUR_____YEAR_____ COVERED_____
INSUR_____YEAR_____ COVERED_____
INSUR_____YEAR_____COVERED_____
OUT OF NETWORK YES_____ NO