

# LORI G. POLACEK, M.D., INC.

Patient Information as of \_\_\_\_\_ (enter today's date)  
(Please Print Legibly & Fill In or Correct All Fields)

## Patient's Name

\_\_\_\_\_

First

Middle

Last

Address \_\_\_\_\_

Street & Apt #

City

State

Zip

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Other Phone \_\_\_\_\_

Any restrictions for contacting you?  No  Yes E-mail \_\_\_\_\_

Contact Restrictions: \_\_\_\_\_

Age \_\_\_\_\_ Birthdate \_\_\_\_\_ SS# \_\_\_\_\_ Gender  Female  Male

Marital Status  Single  Married to: \_\_\_\_\_  Other: \_\_\_\_\_

## Patient's Employer

Occupation \_\_\_\_\_

Work Phone \_\_\_\_\_ Ext: \_\_\_\_\_ Is it okay to call you at work?  Yes  No

Address \_\_\_\_\_

Street & Suite #

City

State

Zip

## How did you hear about our practice?

(Mark all that apply)

Website  Phone Book  Magazine  Online directory  Seminar  Salon  
 Search Engine which one

Friend/Relative: \_\_\_\_\_  Doctor: \_\_\_\_\_  Other: \_\_\_\_\_

If you were referred by a specific person, may we thank them?  Yes  No

Where did you get our phone number

## Emergency Contact

\_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Other Phone \_\_\_\_\_

## Primary Health Insurance Company

Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Ins. Phone \_\_\_\_\_

Referral Required?  No  Yes Copay?  No  Yes, \$ \_\_\_\_\_

Insured: Name \_\_\_\_\_ DOB \_\_\_\_\_ Employer \_\_\_\_\_

## Secondary Health Insurance Company

Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Ins. Phone \_\_\_\_\_

Referral Required?  No  Yes Copay?  No  Yes, \$ \_\_\_\_\_

Insured: Name \_\_\_\_\_ DOB \_\_\_\_\_ Employer \_\_\_\_\_

I understand that office visit charges are payable on the day service is rendered. I authorize Dr. Lori Polacek to bill my insurance company for medically necessary services. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Dr. Polacek and myself.

Signature \_\_\_\_\_ Date \_\_\_\_\_