Lowe & Freyaldenhoven, M.D.s Chartered

☐ **Bettina Lowe, M.D.** ☐ **Kristine Freyaldenhoven, M.D.**

Patient's Full Name: _____ Sex: **Male** **F**emale

Social Security # _____-_____-_____ **Date of Birth** _____ Age _____

Street Address _____ **P.O. Box** _____

City/State _____ **Zip Code** _____

Home Phone (___)_____**Cell Phone** (___)_____ **Work Phone** (_____)_____

Patient's Status: (circle all that apply) Married Single Other Employed Retired Student: Full Time Part Time

Emergency Notification: _____
(Name of person other than spouse) (relationship) (phone# - not same as your home #)

Patient's Employer _____ **Phone** (_____)_____

Business Address _____

Spouse's Name _____ **Occupation** _____

Employer _____ **Phone** (_____)_____

Business Address _____

INSURANCE INFORMATION

Primary Insurance _____**HMO/PPO** **Phone** (_____)_____

Group Name _____ **Group #** _____

Subscriber _____ **Subscriber's Date of Birth** _____

Subscriber's SS# and/or ID#_____**Insurance Company Phone #** _____

Claim Address _____

Secondary Insurance _____ **Phone** _____

Group Name _____ **Group #** _____

Subscriber _____ **Subscriber's Date of Birth** _____

Subscriber's SS# and/or ID# _____**Insurance Company Phone #** _____

Claim Address _____

Primary Care Physician_____**Phone and/or Address** _____

Referring Physician (if different) _____ **Phone and/or Address** _____

I authorize the release of any medical records or other information necessary to process any claim. I also request payment of insurance benefits to: Lowe and Freyaldenhoven, M.D.s Chartered.

Patient or Authorized person Signature: _____ Date: _____