STEPHEN L. ARONOFF, M.D., P.L.L.C. -- PATIENT INFORMATION AND CONSENT

REFERRING PHYSICIAN'S NAME_____**PHONE #** _____

MEDICAL REASON FOR REFERRAL_____

NAME OF PATIENT: _____
First **Middle** **Last**

HOME ADDRESS: _____**CITY:** _____**STATE/ZIP:** _____

PHONE #: Hm:_____**Wk:** _____**Cell:**_____

AGE:_____ **DATE OF BIRTH:**_____**SEX:**_____**DRIVER'S LICENCE #:** _____

PARENT/LEGAL GUARDIAN NAME (if patient is a minor):_____

RELATIONSHIP TO PATIENT:_____**PHONE# Hm:**_____**Wk:**_____**Cell:**_____

HOME ADDRESS:_____**CITY:**_____**STATE/ZIP :**_____

PERSON TO CONTACT IN CASE OF EMERGENCY: _____**RELATIONSHIP:**_____

PHONE #: Hm:_____**Wk:** _____**Cell:**_____

PATIENT'S EMPLOYER: _____

EMPLOYER'S ADDRESS: _____**CITY:**_____**STATE/ZIP:**_____

PATIENT'S MARITAL STATUS (CIRCLE ONE): ☐ **SINGLE** ☐ **MARRIED** ☐ **WIDOWED** ☐ **DIVORCED/SEPARATED**

NAME OF SPOUSE/SIGNIFICANT OTHER : _____**DATE OF BIRTH:** _____

EMPLOYER: _____**WORK PHONE:**_____

EMPLOYER ADDRESS:_____**CITY:**_____**STATE/ZIP:**_____

~ HEALTH INSURANCE INFORMATION~

Name of Insured:_____**Date of birth:**_____

Primary Insurance:_____**Member #:**_____**Group#:**_____

Coverage Verification Phone #:_____

Secondary Insurance:_____**Member #:**_____**Group#:**_____

Coverage Verification Phone #:_____