Today's Date: _____

PATIENT INFORMATION

First Name: _____ MI: _____ Last: _____

DOB: _____ SS#: _____-_____-_____ Marital Status: _____ Gender: M_____ F_____

Address: _____ City: _____ State_____ Zip_____

What is your occupation: _____

Primary Phone#: _____ Email: _____

May we leave a voicemail with results or clinical instructions: Yes_____ No_____

EMERGENCY CONTACTS

Full Name: _____ Relationship: _____ Phone: _____

Legal Guardian or Guarantor (if other than patient):

Name: _____Relationship: _____

Address: _____ City: _____ State_____ Zip_____

Phone: _____ Email: _____

INSURANCE

Please have your insurance card(s) and photo ID available

Primary Carrier Name: _____ Subscriber Name: _____ DOB: _____

Secondary Carrier Name: _____ Subscriber Name: _____ DOB:_____

- I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered service fees and agree to make payment arrangements for outstanding service fees due at the time service is rendered.
- I understand that if I fail to cancel or reschedule an appointment, I may be charged a "No Show" fee.
- I authorize the physician to release any medical information required to process the claim and receive payment of medical benefits.
- I authorize electronic communications from Alexandra Dresel, MD for healthcare maintenance purposes (i.e.,
  emails, phone calls, and Patient Portal messages).

Patient or Legal Guardian Signature: _____ Date: _____

The patient or legal guardian of the patient must sign. Guarantor cannot sign on behalf of the patient.