Michael J. Barimo, D.O.
Marie Christensen, M.D.
Max S. Watzman, D.O.

Name: _____

Address: _____

_____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

May we leave a message? _____ Yes _____ No

Primary doctor:

____Dr. Barimo ____Dr. Christensen ____Dr. Watzman

Email Address: _____

Employer: _____

Address: _____

_____

Employer Phone#: _____

Occupation: _____

Pharmacy: _____

Address: _____

Phone#: _____

Barimo Family Medicine
"We Care About Your Health"

Family History

FAMILY MEMBER		LIVING OR DECEASED	PRESENT AGE OR AGE AT DEATH	MAJOR ILLNESS AND/OR CAUSE OF DEATH
FATHER				
MOTHER				
SIBLINGS (NAME)	CIRCLE SEX			
	M F			
	M F			
	M F			
	M F			
	M F			
CHILDREN (NAME)	CIRCLE SEX			
	M F			
	M F			
	M F			
	M F			
	M F			

Spouse/Partner's name (if applicable): _____

Who referred you to us, or how did you hear about our practice? _____

Do you smoke cigarettes/use tobacco? _____ For how many years? _____ # Per day? _____

If applicable, when did you quit smoking? _____

How much alcohol do you drink on an average daily, weekly, or monthly basis? _____

List all surgeries you have had and approximate dates? _____

_____

List all medications you are allergies to or have had reactions to: _____

_____

List all medications you are currently taking with dosages: _____

_____

_____

What major medical problems have you had in your lifetime? (i.e. cancer, diabetes, high blood pressure, ect.)

_____

_____

_____

_____

Local Pharmacy (Name and Phone Number): _____

Mail-Order Pharmacy (Name and Phone Number): _____

Name _____ Signature _____ Date _____

MICHAEL J. BARIMO, D.O.
MARIE CHRISTENSEN, M.D.
MAX S. WATZMAN, D.O.
BENNETT FELD, PA-C

Advance Directives
Yes____ No____

PLEASE PRINT

ADULT PATIENT INFORMATION SHEET

PLEASE PRESENT INSURANCE CARDS FOR COPYING

NAME:_____ AGE:_____ DATE OF BIRTH:_____

STREET ADDRESS:_____ CITY & STATE:_____ ZIP:_____

HOME PHONE: ( )_____ BUSINESS PHONE: ( )_____

SOCIAL SECURITY #:_____ DRIVER'S LIC. #:_____ STATE:_____

MARITAL STATUS: M S D KNOWN ALLERGIES:_____

PLACE OF EMPLOYMENT:_____ OCCUPATION:_____

EMPLOYER ADDRESS:_____

SPOUSE INFORMATION

NAME:_____ AGE:_____ DATE OF BIRTH:_____

SOCIAL SECURITY #:_____ BUSINESS PHONE: ( )_____

PLACE OF EMPLOYMENT:_____ OCCUPATION:_____

INSURANCE INFORMATION

PRIMARY INSURANCE:_____ POLICY/GROUP #:_____

ADDRESS:_____

GROUP EMPLOYER NAME:_____ POLICY OWNER/_____

SECONDARY INSURANCE:_____ POLICY/GROUP #:_____

ADDRESS:_____

GROUP EMPLOYER NAME:_____ POLICY OWNER/_____

HOW DID YOU HEAR ABOUT US?_____

NEXT OF KIN (NOT IN THE SAME HOUSEHOLD)

NAME:_____ RELATIONSHIP:_____

ADDRESS, CITY, STATE & ZIP:_____

_____ PHONE #:_____

***PLEASE READ THE INFORMATION ON THE REVERSE AND SIGN WHERE INDICATED.**

PLEASE READ AND SIGN BELOW

1. I AUTHORIZE PAYMENT DIRECTLY TO MICHAEL J. BARIMO, D.O., P.A., BY MY INSURANCE COMPANY. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL DEDUCTIBLES AND CO-INSURANCE PAYMENTS.

2. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY MEDICAL CLAIMS.

3. ALL OFFICE VISITS MUST BE PAID FOR UPON RECEIPT OF SERVICE, UNLESS PREVIOUS ARRANGEMENTS HAVE BEEN MADE WITH THE OFFICE MANAGER OR BOOKKEEPER.

4. THIS OFFICE ACCEPTS MEDICARE ASSIGNMENT, HOWEVER, THE PATIENT MUST SUBMIT ALL SECONDARY INSURANCE CLAIMS, UNLESS PATIENT HAS MEDIGAP COVERAGE.

5. ALL HMO'S ARE REQUIRED TO PAY APPROPRIATE CO-PAYMENT AT TIME OF SERVICE TO AVOID CANCELLATION OF INSURANCE.

6. WE WILL FILE, AS A COURTESY, GROUP INSURANCE CLAIMS FOR SERVICES RENDERED, HOWEVER, IF PAYMENT IS NOT RECEIVED WITHIN 30 DAYS THE BALANCE BECOMES THE PATIENT'S RESPONSIBILITY.

7. THERE WILL BE A $25.00 CHARGE FOR EACH CHECK THAT IS RETURNED BY YOUR FINANCIAL INSTITUTION.

8. THERE WILL BE A $25.00 CHARGE FOR ALL MISSED APPOINTMENTS WITHOUT 24 HOURS ADVANCED NOTICE OF CANCELLATION.

_____

SIGNATURE DATE

MICHAEL J. BARIMO, D.O.
MARIE CHRISTENSEN, M.D.
MAX S. WATZMAN, D.O.

I, _____ *authorize the following people to have*
(Print patient's name here)

access to my medical information including referrals, prescriptions, appointments, lab reqs, and reports. ie: (Family, friends, or no one)

Please print names:

_____

_____

_____

_____

_____

_____

_____

_____
Signature

_____
Date