DRS. LAHIRI & MESIBOV, LLC

Patient Name: ____ **Date of Birth:** _______________

Address/City/State/Zip: ____

Home Phone: ________________________________ **Leave message?** ☐

Cell Phone: ________________________________ **Leave message?** ☐

Work Phone: ________________________________ **Leave message?** ☐

Social Security Number: ______________________ **Marital Status:** _____________________

Email Address: ____________________________________ **Patient Portal: YES** ☐ **NO** ☐

Race (Please circle one): Asian American Indian/Alaska Native Native Hawaiian/Other Pacific African American White Hispanic Other: _________________

Ethnicity (Please circle one): Hispanic/Latino Not Hispanic/Latino Other: ___________________

Primary Language: _____________________________ **Translator Needed?** ☐

Employer Name: ____________________________ **or School Name:** _______________________

Emergency Contact: ___________________________ **Phone:** _____________________________

Relation: ______________________

Preferred Pharmacy Name: _________________________________ **City:** ___________________

Insurance Information

1. **Primary Insurance Name:** ____

Subscriber Name: ______________________________ **Subscriber DOB:** _____________________

ID#: ____ **Group #:** ___________________________

Relation: _____________________________________

2. **Secondary Insurance Name:** ____

Subscriber Name: ______________________________ **Subscriber DOB:** _____________________

ID#: ____ **Group #:** ___________________________

Relation: _____________________________________

☐ I authorize Drs. Lahiri & Mesibov, LLC to release any medical information including information about prescriptions, test results, appointment times, appointment scheduling, and billing to the following individuals: (Personal contacts only. No Physicians.) **PLEASE LIST NAMES AND RELATIONSHIP**.

Name: __________________________________ Relationship: _____________________________

Name: __________________________________ Relationship: _____________________________

Name: __________________________________ Relationship: _____________________________

☐ I do not authorize any medical information to be released or discussed with anyone other than myself.

Patient Signature: ____ **Date:** __________________