New Patient Demographics

Holistic Einstein

219 Mill St., Rockport, ME 04856

Phone: 207-470-0499 Fax: 207-221-5707

Web: www.holistic-einstein.com Email: dan@holistic-einstein.com

Patient Name:_____ Date of Birth:_____

Primary Address:_____ City:_____ State: ____ Zip Code:_____

Patient Email:_____ Gender: _____

Does the patient have their own phone? If so, please list it here, and circle Y/N to show if I can leave messages with private health information. (Y/N):_____

Mother's Name:_____ Email:_____

Address (if different):_____ City:_____ State: ____ Zip Code:_____

Telephone numbers: Please list anywhere it would be OK to call. Circle Y/N to show if I can leave messages with private health information.

Home (Y/N) _____Cell: (Y/N) _____Work (Y/N) _____

Father's Name:_____ Email:_____

Address (if different):_____ City:_____ State: ____ Zip Code:_____

Telephone numbers: Please list anywhere it would be OK to call. Circle Y/N to show if I can leave messages with private health information.

Home (Y/N) _____Cell (Y/N) _____Work (Y/N) _____

Please use this space to list any other primary caretakers or guardians who might accompany the patient to an office visit. Feel free to use the back of this page if there are more than one.

Name:_____Relationship:_____ Email:_____

Address (if different):_____ City:_____ State: ____ Zip Code:_____

Telephone numbers: Please list anywhere it would be OK to call. Circle Y/N to show if I can leave messages with private health information.

Home (Y/N) _____Cell: (Y/N) _____Work (Y/N) _____

Can we discuss your medical care with anyone else (other relative, sibling)? If so, please list name and relationship:_____

Emergency Contact Name:_____Relationship:_____Phone:_____

I consent to have my child evaluated and treated, I have received a copy of the Notice of Privacy Practices and Practice Policies, and agree to the uses of my personal information described.

Signed (Parent/Guardian):_____ Date:_____

New Patient Insurance Information

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Primary Insurance Company_____

(If you do not have insurance, write "none" above and leave the rest of this page blank)

Subscribers Name_____Relationship to Patient_____

ID Number_____ Group Number_____

Group Name_____ Copay_____ Date of Issue_____

Secondary Insurance Company_____

(If you do not have secondary insurance, write "none" above and leave the rest of this section blank)

Subscribers Name_____Relationship to Patient_____

ID Number_____ Group Number_____

Group Name_____ Copay_____ Date of Issue_____