105 Tenpenny St
Freeport, ME 04032

219 Mill St.
Rockport, ME 04856

Patient Name:_____ Date of Birth:_____

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

Email:_____ Gender: _____

Telephone numbers: Please list anywhere it would be OK to contact you. Circle Y/N to show if I can leave messages with private health information.
Home Y/N _____Cell Y/N :_____Work Y/N :_____

Please list an emergency contact:
Name:_____Phone:_____Relationship:_____
Can we share your medical information with them even if there's no emergency Y/N ?

Can we discuss your medical care with anyone else (spouse, child)? If so, please list name(s) and relationship(s):_____

_____

Primary Insurance (I do not take insurance, but use this information when I do referrals):

Company_____
(If you do not have insurance, write "none" above and skip to the next section)

Subscribers Name_____Relationship to Patient_____
ID Number_____ Group Number_____
Group Name_____Copay_____ Date of Issue_____

Do you have Secondary Insurance? Y/N If yes, please use the back of this page to answer all of the above questions for your secondary insurance.

Y/N Please use email to communicate with me. I understand that email is not secure and that private health information could be exposed. This agreement is completely optional, and I know I can securely contact Dr Einstein by phone or patient portal. I can change my mind at any time.

I have received a copy of the Notice of Privacy Practices and Practice Policies, and agree to the uses of my personal information described in those documents.

Signed (Patient or Guardian):_____ Date:_____