105 Tenpenny St
Freeport, ME 04032

219 Mill St.
Rockport, ME 04856

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):________________

Parent/Guardian 1 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):__________________

Parent/Gardian 2 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):__________________

Can we discuss your medical care with anyone else (grandparent, friend, sibling)? If so, please list name and relationship:____

Emergency Contact Name:_________________________Relationship:__________Phone:___________

Can we share your medical information with them even if there's no emergency (Y/N)?

Y/N Please use email to communicate with me and my child. 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 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:______________

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

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______________