Robert Grossman, M.D.

Name_____Birthdate_____Age_____SS#_____

Race / Ethnicity _____

Address_____City_____St_____Zip_____

Home Phone _____Work Phone _____ext _____Cell Phone _____

Preferred method of contact for routine results (please mark one): home#_____ work# _____ cell# _____ e-mail _____

E-mail address (for access to patient portal) _____

Please initial: I give my authorization: email address will be used to create access to a patient portal_____

Pharmacy Name/Phone/City _____

Employer_____Occupation_____

Employer Address_____City_____St_____Zip_____

Marital Status (circle one): Single Married Divorced Widowed

Spouse's Name_____Birthdate_____Age_____SS#_____

Employer_____Occupation_____Work Phone_____

Emergency Contact _____**Phone** _____**Relationship**_____

Referred By_____

History

Major Illnesses/Surgical Procedures:_____

_____

Current Medications:_____

_____

Allergies to Medications:_____

Pregnancies_____ Vaginal Deliveries_____ C/S Deliveries_____

Financial

Primary Insurance _____ Policy/ID# _____

Name of Subscriber _____ Relation to Insured _____

Subscriber's SS# _____ Subscriber's Birthdate _____

Your signature below is required to acknowledge our financial policies.
As a private paying patient, I agree to be financially responsible for charges incurred as a result of services provided to me by the Dr.'s Grossman.

Patient Signature (or Parent of Minor) _____Date_____

As an insured patient, I agree to the following terms. Insurance is a contract between the patient and the insurance company. Our office submits claims as a courtesy to patients. As the patient I am financially responsible to the Dr.'s Grossman for services rendered regardless of coverage. I fully understand that the Dr.'s Grossman may not accept my insurance companies usual and customary fees as payment in full. This may lead to my receiving a bill for deductibles, co-pays, co-insurance and non-covered items. I agree to pay for any such balance.
I hereby authorize my insurance company to pay all benefits directly to the Dr.'s Grossman. I also authorize Grossman & Grossman, M.D.'s to release any medical information to my insurance carrier necessary to complete processing of any pending claims.

I understand that Grossman & Grossman, M.D.'s, or any company acting on their behalf, may use various dialing and communications methods to reach me at the telephone number(s) I have provided. This includes, but is not limited to dialing or texting my wireless telephone number, which could result in charges by my wireless carrier, either manually or through the use of automatic dialing technology and/or prerecorded messages.

Patient Signature (or Parent of Minor) _____Date_____