Abe Medical

Please complete all sections. Print clearly.

Date: _____

## I. Patient Information:

Full Legal Name: _____

Current Address: _____

City, State Zip Code: _____

Date of Birth: _____ SS#: _____ Gender: Male Female

Phone Number: Home:_____Cell: _____ Work: _____

Email Address: _____

Marital Status: Single Married Divorced Widowed

Emergency Contact Name: _____

Emergency Contact Phone: _____ Relationship: _____

## II. Insurance Information:

Primary Insurance Company: _____

ID/Policy #: _____ Group #: _____

Secondary Insurance Company: _____

ID/Policy #: _____ Group #: _____

Name of Insured (if different): _____

Relationship to Patient: _____ DOB of Insured: _____

## III. Reason for Visit & Medical History:

Reason for Visit: _____

Medical History: _____

_____

Medications: _____

_____

Allergies: _____

I hereby consent to medical examination, diagnosis, and treatment by Abe Medical, PLLP and their authorized staff, as deemed necessary for my care.

_____