**Dr. Nate Greenstein**
**Patient General information**

Please complete this general information form. Be as complete and accurate as possible. If something does not apply, record the word **"none"** for that item
***Please print or type.***

Today's Date: ______________________ Social Security # ______________________

Legal Name: ______________________________________________
Last First Middle (Nickname)

Birthdate: __________ Age: __________ Home Phone: __________ Cell Phone: __________

Email Address: ______________________ Fax #: __________

Local Home Address: ______________________ Apt #: __________

City: __________ State: __________ Zip Code: __________

Marital Status: ☐M ☐S ☐W ☐D or ☐Separated Sex: ☐M ☐F # of children: __________

Occupation: __________ Employed by: __________

Employer's Address: ______________________ Ste #: __________

City: __________ State: __________ Zip Code: __________ Bus. Phone: __________

Spouse's Name: ______________________

Spouse's Occupation: __________ Employed by: __________

Nearest relative not living with you: __________ Phone: __________

Nearest friend not living with you: __________ Phone: __________

Physician: __________ Phone: __________

Dentist: __________ Phone: __________

Landlord: __________ Phone: __________

Who may we contact in case of emergency: __________ Phone: __________

Who may we thank for referring you to us: __________ Phone: __________

## Financial Arrangements

Check appropriate one(s):

- ☐ Private Pay (Cash, Check, or Credit Card)
- ☐ Individual Health Insurance
- ☐ Group Health Insurance
- ☐ Medicare
- ☐ Automobile Insurance
- ☐ Worker's Compensation
- ☐ Other __________

If insurance coverage:

Company Name: ______________________

Company Address: ______________________

Company Phone #: ______________________

Insured's Name: ______________________

Insured's Social Security #: ______________________

Insured's Date of Birth: ______________________

Policy #: ______________________

Claim #: ______________________

Group Name and/or #: ______________________

Medicare #: ______________________

Other Type of ID #: ______________________

If accidental injury, do you have an attorney that represents you? ☐ No ☐ Yes
If yes, what is the attorney's name, address and telephone number: ______________________

**Please read, sign and date the following:**

I am ultimately financially responsible for my account even if insurance coverage is available. The information is accurate to the best of my knowledge. I will notify you of any future changes with my general information.

Patient/Legal Guardian: ______________________ Date: __________