

ANNA PETROPOULOS, MD, FRCS
80 Lindall Street, Danvers, MA 01923

DATE: _____

PERSONAL INFORMATION:

First Name: _____ Last: _____ M.I.: _____ Age: _____

Phone:(H) _____ (W): _____ (C): _____ Email: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Sex: M ___ F ___ Date of Birth: _____ Marital Status: _____ SS#: _____

Primary Care Physician: _____ Primary Care Physician Phone: _____

Patient Employer: _____ Occupation: _____

Reason for this visit: _____

INSURANCE INFORMATION:

Do you have medical insurance? Y ___ N ___ Name of Insurance Company: _____

Name of Subscriber: _____ Relationship: _____

Subscriber Employer: _____ Insurance ID#: _____

Name of Secondary Insurance (if any): _____ ID#: _____

MEDICAL INFORMATION:

In case of emergency, name and phone number of person to be notified: _____

Do you have any medical conditions? If so, please specify: _____

Please list any medications you take regularly: _____

Please list any medications you are allergic to: _____

Do you smoke? ___ How many daily: ___ # of years: ___ Alcohol consumption: ___ daily ___ weekly ___ seldom ___ never ___

WHERE DID YOU HEAR OF OUR OFFICE?

Name of personal referral: _____ Yellow Pages: ___ Magazine: ___ Internet: ___ Spa: ___ Other: _____

Assignment of Insurance Benefits

The undersigned hereby authorizes the release of any information relating to all claims for benefits on behalf of myself and/or dependent. I further expressly agree and acknowledge that my signature on this document authorizes Anna Petropoulos, MD to submit claims for benefits, services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or my dependents and that I will be bound by this signature as though the undersigned had personally signed the particular claim. Finally, I have been informed that it is my responsibility to obtain referrals from my insurance carrier and/or primary care physician. I agree to be personally responsible for any and all of my medical expenditures which are not covered by my insurance plan, and/or those that result in the event that I have not obtained the proper referrals.

Authorized Signature of Subscriber

Date