Lisa B. Arian, M.D.
Lynne Champagne, M.D.

PATIENT INFORMATION FOR MEDICAL RECORDS – *PLEASE PRINT CLEARLY*

NAME (Mr. Mrs. Ms.) _____
Last First M.I.

HOME ADDRESS _____

_____
City State Zip

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

D.O.B. _____ AGE_____ SEX_____ SSN _____ MARITAL STATUS: MARRIED SINGLE WIDOWED MINOR

EMPLOYED BY _____ OCCUPATION_____

WORK ADDRESS _____

EMERGENCY CONTACT _____ PHONE NUMBER _____
Last First

MEDICAL INSURANCE INFORMATION

PRIMARY INSURANCE CO._____ ADDRESS_____

POLICY NUMBER_____ PHONE NUMBER_____GROUP NAME/#_____/_____

SECONDARY INSURANCE CO. _____ ADDRESS_____

POLICY NUMBER_____ PHONE NUMBER_____GROUP NAME/#_____/_____

ARE YOU BEING SEEN FOR AN INJURY? YES_____ NO_____ IS IT JOB RELATED?_____

There will be a $25.00 fee for No Show or Cancellation with less than 24 hours notice.

PLEASE SIGN AND RETURN TO RECEPTIONIST

I, THE UNDERSIGNED, ASSIGN DIRECTLY TO DR. ARIAN OR DR. CHAMPAGNE MEDICAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I HEREBY AUTHORIZE DR.ARIAN AND DR. CHAMPAGNE TO RELEASE ALL INFORMATION NECESSARY TO SECURE PAYMENT OF BENEFITS.

SIGNATURE X_____ DATE_____
IF PATIENT IS A MINOR, SIGNATURE OF PARENT OR GUARDIAN AUTHORIZING TREATMENT

NOTE: PLEASE NOTIFY US IF ANY OF THE ABOVE INFORMATION CHANGES DURING THE COURSE OF YOUR TREATMENT