RESERVOIR MEDICAL ASSOCIATES

Patient Questionnaire

Patient Name

Sex: ☐ Male ☐ Female Date of Birth _____ Social Security (last 4 digits) _____

Last _____

First: _____

Middle _____ Prefix: _____ Suffix: _____

Race: _____ Ethnicity: _____ Occupation: _____

Preferred Language _____

Primary Care Doctor

☐ Lisa Golding, M.D.

☐ A. Margaret Sandin, M.D.

☐ Debra Shapiro, M.D.

☐ David Shein, M.D.

☐ Ricardo Wellisch, M.D.

Mailing Address

Street Address _____

City _____ State _____ Zip _____

Telephone Numbers

Primary ( ) _____ ☐ Home ☐ Cell ☐ Work

Secondary ( ) _____ ☐ Home ☐ Cell ☐ Work

Tertiary ( ) _____ ☐ Home ☐ Cell ☐ Work

Emergency Contact

Name: _____ Relationship to patient _____

Telephone # ( ) _____ ☐ Home ☐ Cell ☐ Work

Insurance Information:

Name of Primary _____ Effective Date: _____

ID Number _____ Suffix _____

Name of Secondary _____ Effective Date: _____

ID Number _____ Suffix _____

Are you the primary subscriber? ☐ Yes ☐ No *(if no please list Name and DOB on next line)*

Please list the Primary's name _____ Date of birth _____

Please check all that apply

Do you have advance directives? ☐ Yes ☐ No

Please be sure we have a copy of these in our files.

☐ Health Care Proxy ☐ Living Will ☐ Organ Donor

Health Care Proxy

Name: _____

Telephone # ( ) _____

Local Pharmacy Information

Name: _____

Address: _____

_____

Mail Order Pharmacy

Name: _____

Mail Order ID # _____