



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.
- Lydia Barlow, M.D.
- Ricardo Wellisch, M.D.
- Mary Katz, N.P.

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 # _____