YELENA LAPIDUS MD

Personalized Medicine for Healthy Longevity

Patient Information Registration

Patient Information

Name: Last:		Referring Provider:	
First:	MI:	Rendering Provider:	
Previous Name:		D.O.B.:	Age:
Address Line 1:		Sex: M / F	
Address Line 2:		Marital Status:	☐ S ☐M ☐ D ☐W
City:		SS#:	
State:	Zip:	Employer Name:	
Home Phone:	Cell #:	Status:	
Work Phone:	Ext:	Student Status:	
Pharmacy:		**Street:**	**City:**

Billing Information *(if different than above):* Circle One: *Guarantor / Spouse / Parent*

Name: Last:	First:	MI:	
Relationship:	SS#:	Sex: M / F	
Mailing Address:			Zip:
Home Phone #:		Cell Phone#:	
Employer:		Occupation:	
Employer Address:		Employer Phone#:	

Advance Directive	***Yes No***	***Organ Donor***	***Yes No***

Insurance Information *(Insurance Cards must be provided with Drivers License)*

Subscriber's Name:

Subscriber SS#: (if different than above**)** _____/_____/_____ **Relationship to Patient***: ☐Self ☐Spouse ☐Child ☐Parent*

Primary Insurance Name:		**Secondary Insurance Name:**	

Yelena Lapidus, M.D., Inc.

In Case of Emergency Information			
Name of a local friend or relative (not living with you):			**Relationship:**
Emergency Contact #'s	**Home:**	**Work:**	**Cell:**
I give permission for staff to leave messages on my cell phone or answering machine. I give permission for staff to call my name in the reception area. Please initial here if the above statements are correct _____			
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for my balance. I also authorize Dr. Lapidus and/or insurance companies to release any information required to process my claims.			
My Spouse and/or _____ may have access to any of my records/information at Dr. Lapidus:(Circle one) **Yes No N/A**			
Patient Signature:			***Date:***