

CAROLE COOK, MD
PATIENT DATA SHEET

PLEASE PRINT CLEARLY

DATE _____ PT# _____

HOME TEL# () _____
WORK TEL# () _____
CELL/PAGER# () _____

NAME _____ BIRTHDATE _____ SS# _____

HOME ADDRESS _____ CITY _____ ST _____ ZIP _____

PATIENT'S EMPLOYER _____ POSITION _____ F/T ___ P/T ___

MARITAL STATUS: () SINGLE () MARRIED () SEPARATED () DIVORCED () WIDOWED

SPOUSE'S NAME _____ BIRTHDATE _____

SPOUSE'S EMPLOYER _____ POSITION _____ WORK# () _____

REFERRED YOU TO OUR OFFICE? _____

PRIMARY CARE PHYSICIAN _____ OFFICE TEL# () _____

1. If it becomes necessary to contact you by phone, do we have your permission to leave messages regarding lab results and/or appointments on your answering device, or with another person who answers the phone? Yes _____ No _____

2. What is the best time of day to reach you? _____

3. Where do you prefer to receive calls? Home _____ Work _____ Cell _____ Pager _____

4. Name of emergency contact person (not living with you)? _____
Phone# _____

INSURANCE DATA

1. ARE YOU COVERED UNDER YOUR OWN INSURANCE? () YES () NO

INSURANCE CO NAME _____ EFFECTIVE DATE _____

2. ARE YOU COVERED UNDER YOUR SPOUSE'S INSURANCE POLICY? () YES () NO

INSURANCE CO NAME _____ EFFECTIVE DATE _____

***IF MINOR OR INSURED BY PARENT OR GUARDIAN, PLEASE COMPLETE THE FOLLOWING INFORMATION:**

INSURANCE CO NAME _____	EFFECTIVE DATE _____
Policy Holder's Relationship to Insured _____	
Policy Holder's Name _____	
Policy Holder's Date of Birth _____	