Eugenio Menendez, D.O., P.A.

d/b/a **Pompano Beach Internal Medicine**

Office of **Eugenio L. Menendez, D.O., F.A.C.P.**

Board Certified -- Internal Medicine

www.PompanoBeachInternalMedicine.com

NEW PATIENT INTAKE-REQUIRED INFORMATION

FULL NAME: ____**DATE:** ______________________

DATE OF BIRTH: __________________ **SSN:** ____________________________ **AGE:** ____ **SEX:** M F

CELL PHONE: (_____)________________**HOME:** (_____)___________________**WORK:** (_____)____________

ADDRESS: ____**APT:** ________

CITY, STATE: ____**ZIP CODE:** _________________

DRIVERS LICENSE: **STATE**: _______ **DRIVER'S LICENSE NUMBER:** ____

EMAIL ADDRESS: ____**OCCUPATION:** ___________________

MARITAL STATUS: SINGLE WIDOWED DIVORCED MARRIED/SPOUSE FULL NAME: __________________________

EMERGENCY CONTACT NAME: ____

RELATIONSHIP (SPECIFY RELATIVE OR CARETAKER) ___________________________________

CELL: (_____)_____________ EMAIL: ____

REFERRED BY (VERY IMPORTANT): Full name (if applicable): ____

Referral By: DOCTOR RELATIVE FRIEND CURRENT PATIENT OTHER:_____________________

** I Authorize (Full name) ____ (Cell) _________________

(Mailing Address) ____

(Email Address) ________________________________ to receive my medical information if I am not available.**

(MUST PROVIDE PROOF OF INSURANCE AT EACH VISIT)

INSURANCE INFORMATION:

PRIMARY INSURANCE: ____ POLICY#: _____________________

Guarantor (If other than patient):

NAME: ____ *GUARANTOR DATE OF BIRTH:* _________

SECONDARY INSURANCE:___________________________________POLICY#: _________________________

LIVING WILL: YES NO **IF YES,** were documents given to us YES NO

Do you have a HEALTHCARE SURROGATE? YES NO IF YES, please provide contact information below:

Name: ____Phone: __________________________

Mailing Address: ____

Email Address: ____

HIPPA POLICY SIGNED: YES NO