J.T. Lee, M.D., P.A. – Internal Medicine

New Patient Demographics

Please fill out and return as soon as possible to: 669 Revolution Street, Havre de Grace, MD 21078 **OR fax to: (410) 939-2329

Patient Information:

☐ New patient ☐ Established patient Date: _____/_____/_____

Last Name First Name Middle Initial

Address

City State Zip Code

Home Phone Work Phone Cell Phone

E-mail Address Marital Status

Social Security Number: _____ - _____ - _____ Date of Birth: _____ / _____ / _____ Sex: ☐ Male ☐ Female

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ More than one race ☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Decline to Specify

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Specify **Preferred Language**:_____

Emergency Contact:

Last Name First Name Middle Initial

Address

City State Zip Code

Home Phone Work Phone Cell Phone

E-mail Address Relationship

Insurance

What is the name of your insurance provider: ☐ Medicare ☐ Medicaid ☐ BC/BS

Other (Please Specify): _____ Effective Date: _____ / _____ / _____

/

Name of policy holder: Last Name First Name Middle Initial Relationship to Patient

Address of policy holder if not the same as Patient's

City State Zip Code

Phone: (_____) _____ - _____

Social Security Number of Policy Holder: _____ - _____ - _____

Insurance Identification Number: _____ Group Identification Number: _____