Peter M. Levine, M.D., LLC
Patient Registration and Acknowledgement of Forms

Demographic Information

Today's Date:_____/_____/_____

Full legal name: _____ Preferred Name: _____

Marital Status: ___ Married ___ Single ___ Divorced ___Separated ___Widowed ___Other
Gender: ____Male ____Female
Date of Birth: _____/____/_____ Age: _____
Social Security Number: _____ Driver's License Number: _____
Address: _____
City, State, Zip: _____
Cell Phone: _____ OK to leave message? ___Yes ___No
Home Phone: _____ OK to leave message? ___Yes ___No
Work Phone:_____ OK to leave message? ___Yes ___No
Email:_____ OK to send message? ___Yes ___No

Guarantor/Financially Responsible Party
Name:_____ Relationship to Patient:_____
Address: _____
Tel: _____

Spouse/Partner's Full Name: _____

Occupation: _____
Employer/Address:_____

Referring/Primary Care Physician:_____
Address/Phone: _____

How did you hear about my practice? _____
What was the main reason why you chose my practice? _____

In Case of Emergency
Name of local friend or relative (not living at same address): _____
Relationship: _____ Home Phone: _____
Cell phone: _____ Work Phone: _____

The above information is true to the best of my knowledge. I certify that this office has provided me with a copy of its ***Policies & Procedures for Patients and Consent for Treatment***, and I agree to its terms, including the payment policy, email policy, and no show policy. I certify that the office given me an opportunity to review its ***Notices of Privacy Policies***, and I agree to its terms. I understand that I am responsible for payment in full at the time services are rendered. I understand that Dr. Levine does not participate with Insurance Plans and he has opted out of participating with Medicare, and that Medicare beneficiaries cannot submit claims for payment to Medicare for services rendered by Dr. Levine. I authorize Dr. Levine to release medical information to my referring or primary physician to assist with continuity of care.

Signature: _____ Date: _____