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David L. Chesler, M.D.
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Laura A. Ricciardi, M.D.
Kathryn J. Jaquette, F.N.P., C.N.M.
Deborah M. Long, F.N.P.
Pamela A. Tetro, F.N.P., C.D.E.
Jane J. Miller, F.N.P., C.D.E.

Welcome to our office. In order to serve you properly, we will need the following information. **(Please Print)**
All information will be strictly confidential.

Todays Date: ____________________

Patient's Name	Sex ❑ M ❑ F	Birth Date ______/______/______ Age __________	Marital Status Single ❑ Married ❑ Widowed ❑ Divorced ❑
911 Address City State Zip Mailing Address City State Zip	Home Phone _____/_____/______ Cell Phone _____/_____/______ Evening Phone _____/_____/______ Best # Reached during working hours _____/_____/______	Social Security # ______________ Email:	
Person Financially Responsible for this account	❑ Self ❑ Spouse ❑ Parent	Responsible Party Birthdate _____/_____/_____	Responsible Party Soc Sec # ______________
Responsible Party Drivers License # State	Phone #	Occupation	How long at current employer?
Name of employer	Address	Business Phone #	Occupation
Name of Spouse/Parent	Birth date _____/_____/_____	Social Security # ______________	Business Phone #
How did you learn about our practice?			
Person to contact in case of emergency:	Relationship to patient	Phone #	
Medicare ❑ Yes ❑ No	Medicare #	Medicaid ❑ Yes ❑ No	Medicaid #
Effective Date _____/_____/_____			
Medicare Secondary Insurance name	Address	Policy #	Group #
Workers Compensation? ❑ Yes ❑ No Motor Vehicle? ❑ Yes ❑ No **If MVA continue below**	Date of Accident	Treatment authorized by	Claim #
W/C or MVA Insurance Phone # _____/_____/_____ Fax # _____/_____/_____			
Primary Insurance name	Address	Is insurance through your emplyer? ❑ Yes ❑ No	
Subscriber Name	Subscriber Birth date _____/_____/_____	Policy #	Group #
Secondary Insurance name	Address	Policy #	Group #