

# RAANANAH S. KATZ, M.D., F.A.C.S.

## PATIENT INFORMATION

(PLEASE PRINT CLEARLY)

DATE \_\_\_\_\_  
NAME \_\_\_\_\_  
ADDRESS \_\_\_\_\_ APT# \_\_\_\_\_ BLDG.# \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_  
PHONE NUMBER \_\_\_\_\_  
SOCIAL SECURITY NUMBER \_\_\_\_\_  
BIRTHDATE \_\_\_\_\_ AGE \_\_\_\_\_ MARITAL STATUS: S M W D

OUT OF STATE ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_  
PHONE NUMBER \_\_\_\_\_

### EMPLOYER INFORMATION

YOUR EMPLOYER \_\_\_\_\_ TITLE \_\_\_\_\_  
WORK PHONE NUMBE \_\_\_\_\_  
SPOUSE'S NAME \_\_\_\_\_ EMPLOYER \_\_\_\_\_  
TITLE \_\_\_\_\_ WORK PHONE NUMBER \_\_\_\_\_

### CONTACT IN CASE OF EMERGENCY

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_  
PHONE NUMBER \_\_\_\_\_

### IF PATIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING:

NAME OF GUARDIAN \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_  
EMPLOYER \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_

### PLEASE COMPLETE THE FOLLOWING:

WHO IS YOUR FAMILY DOCTOR? \_\_\_\_\_  
ARE YOU ALLERGIC TO ANY MEDICATIONS? \_\_\_\_\_  
ARE YOU TAKING ANY MEDICATIONS? \_\_\_\_\_  
WHO CAN WE THANK FOR REFERRING YOU TO OUR OFFICE? \_\_\_\_\_

### INSURANCE INFORMATION

**PRIMARY INSURANCE COVERAGE** \_\_\_\_\_  
NAME OF INSURED \_\_\_\_\_  
RELATIONSHIP TO INSURED: SELF \_\_\_\_\_ SPOUSE \_\_\_\_\_ DEPENDENT \_\_\_\_\_  
ID# \_\_\_\_\_ GROUP # \_\_\_\_\_

**SECONDARY INSURANCE COVERAGE**  
NAME OF INSURED \_\_\_\_\_  
RELATIONSHIP TO INSURED: SELF \_\_\_\_\_ SPOUSE \_\_\_\_\_ DEPENDENT \_\_\_\_\_  
ID# \_\_\_\_\_ GROUP # \_\_\_\_\_