ROBERT PLATZMAN, D.O.

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PRINCETON, NJ 08540
OFFICE (609) 921-8766 FAX (609) 609-608-9492

LAST NAME: _____ **FIRST NAME:** _____ **DOB:** _____

ADDRESS: _____ **Male/Female (circle)**

HOME PHONE: _____ **CELL PHONE:** _____ **WORK:** _____

PREFERRED NUMBER TO CALL: **Home/Cell/Work** **EMAIL:** _____

EMPLOYER: _____ **OCCUPATION:** _____

NAME OF SPOUSE/PARENT: _____ **MARITAL STATUS:** _____

EMERGENCY CONTACT: _____ **EMER. PHONE:** _____

ALLERGIES TO MEDICATION(S): _____

REASON FOR VISIT: _____

MEDICAL CONDITIONS: _____

LAST PHYSICAL/WELL VISIT _____ **RECENT HOSPITALIZATIONS?** _____

MEDICATION LIST: _____

_____

PRIMARY INSURANCE: _____ **SECONDARY:** _____

ID#: _____ **GRP:** _____ **ID#** _____ **GRP:** _____

CLAIM ADDRESS: _____ **ADDRESS:** _____

_____ _____

SUBSCRIBER: _____ **DOB:** _____ **SUBSCRIBER:** _____ **DOB:** _____

I understand that I am financially responsible for all charges for services rendered including balances unpaid by my insurance carrier. I further authorize payment of medical benefits to the above physician as well as the release of any medical information necessary to process claims. There will be a $25 cancellation fee for appointments cancelled < 1 business day. _____ **Initial**

Signature: _____ **Date:** _____