

Lucie Capek, MD, PLLC
713 Troy Schenectady Road, Suite 308
Latham, NY 12110
(518) 786-1700

Patient Information

Name _____ DOB _____ Age _____

I prefer to be addressed by the name: _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work _____ Cell _____

Employer _____ Occupation _____

SS# _____ E-Mail _____

Marital Status: Single Married Separated Divorced Widowed

If Married, Spouse Name _____ Phone _____

In Case of Emergency Call _____ Phone _____

Primary Care Physician _____ Phone _____

Referring Physician _____ Phone _____

How did you hear of our practice? _____

Pharmacy Phone number _____

If Patient Is a Minor/Dependent Child

Mother's Name _____ DOB _____

Employer _____ Phone _____

Father's Name _____ DOB _____

Employer _____ Phone _____

Insurance Information

Primary Insurance _____ Address _____

Policy Holder _____ Date of Birth _____ ID# _____

Secondary Insurance _____ Address _____

Policy Holder _____ Date of Birth _____ ID# _____

Is treatment related to a Work Accident? _____ Motor Vehicle Accident? _____

If yes, Worker's Compensation Carrier _____ Case # _____

No Fault Carrier _____ Case # _____

Phone _____ Contact Person _____

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my (or my dependent's) account for any professional service rendered. I have completed the above information and certify that it is true and correct to the best of my knowledge. I will notify you of any changes in the above information.

Signature _____ **Date** _____