

Lucie Capek, MD, PLLC  
713 Troy Schenectady Rd. Ste 308  
Latham, NY, 12110

**Patient Information**

Name \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_  
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? \_\_\_\_\_

**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 \_\_\_\_\_ Group# \_\_\_\_\_ ID# \_\_\_\_\_  
Secondary Insurance \_\_\_\_\_ Address \_\_\_\_\_  
Policy Holder \_\_\_\_\_ Group# \_\_\_\_\_ 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 \_\_\_\_\_