



John J. Eck, M.D.
Board Certified Family Physician

David L. Gee, M.D.
Board Certified Family Physician

Julie L. Scott, MPA-C
Physician Assistant

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| PATIENT INFORMATION | |
| Last name: | Date of birth: ___ / ___ / ___ (mm/dd/yyyy) |
| First: M: | Sex: Male ___ Female ___ |
| Nickname (if applicable): | Marital Status circle one: Single / Mar / Div / Sep / Widowed |
| Address: | Social Security #: |
| City: | Employer Name: |
| State: Zip: | Preferred Pharmacy: |
| Home Phone #: Work Phone #: Cell Phone #: | E-mail Address: |
| RESPONSIBLE PARTY (statements will be addressed to responsible party) | EMERGENCY CONTACT |
| Name: | Last Name: |
| Relationship to patient: (i.e., parent, spouse, etc.) | First: |
| Date of birth: ___ / ___ / ___ (mm/dd/yyyy) | Relationship to patient: |
| Address 1: | Address 1: |
| Address 2: | Address 2: |
| City: | City: |
| State: Zip: | State: Zip: |
| Home Phone #: Work Phone #: Cell Phone #: | Home Phone #: Work Phone #: Cell Phone #: |
| INSURANCE INFORMATION (please give your insurance card to the receptionist) | |
| Insurance Name: | Insured's Name: |
| | ID#: COPAY: |
| Address 1: | Insured's relationship to patient: (i.e., parent, spouse, etc.) |
| Address 2: | Group #: |
| City: | Group Name: |
| State: Zip: | Insurance Telephone #: |
| Name of Secondary Insurance: Insured's Name: | Group Name: ID #: |

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize CENTER FOR LIFETIME HEALTH or insurance company to release any information required to process my claims.

IN ADDITION, I acknowledge that I have been informed of the CENTER FOR LIFETIME HEALTH's Notice of Privacy Practices.

X _____
PATIENT / GUARDIAN SIGNATURE DATE: