SILVIA PANITCH, MD
Board Certified in Internal Medicine

GENERAL INFORMATION: Date: _____

Male _____ Female _____

Name: _____ Age _____ Date of Birth _____
LAST FIRST MIDDLE

Address: _____ __Apt # _____City _____ State _____ Zip Code _____

Home Phone: _____Cel Phone _____ Work Phone:_____SS # _____

Occupation: _____ Employer: _____ Address: _____

Employment status: ☐ Full-Time ☐ Part-time ☐ School ☐ Retired ☐ Unemployed ☐ Other

Living Situation: ☐ Alone ☐ Friend(s) ☐ Partner ☐ Spouse ☐ Parents ☐ Number of Children
___

Name and Ages of those living with you: _____

_____

Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Name of Partner/Spouse/Parent _____ Occupation: _____
(CIRCLE ONE)
In Case of Emergency Notify:_____ Phone: _____

Educational background: _____

e-Mail: _____

Pets: _____

How did you hear about us: : ☐ Phone book ☐ Ad ☐ Another patient ☐ Course/Seminar taught by:
_____ Physician/Professional ☐ Articles Written by or Referring to _____ ☐ Other

FINANCIAL AGREEMENT:

I _____ claim full financial responsibility for services rendered at Dr. Silvia Panitch /
(PATIENT)
Lakeview Integrative Medicine and understand that payment is required in full at the time of service:

_____ _____
(SIGNATURE –PATIENT OR PARENT OF MINOR) (RELATIONSHIP TO PATIENT)

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGN BENEFITS:

I hereby authorize the release of any medical information necessary in the processing of my claim. I also authorize payment directly to Dr. Silvia Panitch/Lakeview Integrative Medicine for the medical/surgical benefits:

Date: _____ Signed: _____
(PATIENT OR PARENT OF MINOR)