Dr. Sheila Dobee's Welcome Form

Patient Information

Date _____ Soc. Sec. # _____-_____-_____ Birthdate _____

Name _____
Last Name First Name Middle Initial

Home Phone _____ Cell Phone _____ Work Number _____

Address _____

City _____ State _____ Zip _____ E-mail _____

Sex: ☐ M ☐ F ☐ Minor ☐ Single ☐ Married ☐ Long Term Partner ☐ Divorced ☐ Widowed ☐ Separated

Employer _____ Business Phone _____

How did you hear about Dr. Dobee? _____

Do you have one of the following accounts: YELP_____ GOOGLE+_____

Who should we thank for referring you? _____

Full time college student? ☐ Y ☐ N Name & City of School_____

Primary Insurance

Person Responsible for Account _____
Last Name First Name Initial

Relationship to Patient _____ Birthdate _____ Soc. Sec. # _____

Subscriber ID# _____ Group Number _____

Group Name/Employer Name _____

Privacy Protection

Please list the **names and phone numbers** of family members or significant others, whom we may inform about your medical condition ONLY IN AN EMERGENCY.

_____

Patient Signature _____ Date _____

Signature of Parent/Guardian if patient is a minor _____

Print Name _____ Date _____