



DEBRA G. TENNEN, M.D.

DATE: \_\_\_\_\_

**PATIENT INFORMATION**

NAME: \_\_\_\_\_  M  F

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

TELEPHONE: (HOME) ( ) _____	<input type="checkbox"/> SINGLE
TELEPHONE: (WK) ( ) _____	<input type="checkbox"/> MARRIED
TELEPHONE: (CELL) ( ) _____	<input type="checkbox"/> WIDOWED
DATE OF BIRTH: _____	<input type="checkbox"/> DIVORCED
SOCIAL SECURITY #: _____	
DRIVER'S LICENSE #: _____	
e-MAIL: _____	
OCCUPATION: _____	

Business Address: \_\_\_\_\_

*EMERGENCY CONTACT:* \_\_\_\_\_

*PHONE NUMBER:* \_\_\_\_\_

HOW DID YOU HEAR ABOUT DR. TENNEN? \_\_\_\_\_

**INSURANCE INFORMATION**

MEDICAL INSURANCE: \_\_\_\_\_

POLICY OR GROUP #: \_\_\_\_\_

NAME OF PRINCIPAL INSURED: \_\_\_\_\_

IS PRE-AUTHORIZATION REQUIRED FOR OFFICE VISITS?  YES  NO