



DEBRA G. TENNEN, M.D.

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

**PATIENT INFORMATION**

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

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

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

TELEPHONE: (HOME) (\_\_\_\_) \_\_\_\_\_ SINGLE  
TELEPHONE: (WK) (\_\_\_\_) \_\_\_\_\_ MARRIED  
TELEPHONE: (CELL) (\_\_\_\_) \_\_\_\_\_ WIDOWED  
EMAIL: \_\_\_\_\_ DIVORCED

DATE OF BIRTH: \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_

DRIVER'S LICENSE #: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

Employer Name&address: \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

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

**INSURANCE INFORMATION**

PRIMARY MEDICAL INSURANCE: \_\_\_\_\_ POLICY OR GROUP #: \_\_\_\_\_  
NAME OF PRINCIPAL INSURED: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_  
LAST 4 OF SSN FOR PRINCIPAL INSURED: \_\_\_\_\_

SECONDARY MEDICAL INSURANCE: \_\_\_\_\_ POLICY OR GROUP #: \_\_\_\_\_  
NAME OF PRINCIPAL INSURED: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_  
LAST 4 OF SSN FOR PRINCIPAL INSURED: \_\_\_\_\_