Joseph P. Laukaitis, MD
3 Washington Circle NW, Suite 303
Washington, DC 20037

Today's Date:

Name: _____ Last First Middle	**Age:** _____ **Date of Birth:** (mm/dd/yy) _____ **Referred by**: _____
Home Address: Street: _____ Apartment #: _____ City/State/ZIP: _____	**Phone numbers:** Home: ( ) _____ Work: ( ) _____ Cell: ( ) _____ Does Dr. Laukaitis have permission to send appointment reminders via text message to your cell phone? Yes ☐ No ☐
Occupation: _____ Employed by: _____	**Email Address:** _____ Does Dr. Laukaitis have permission to send you an invitation to his secure electronic medical record patient portal? Yes ☐ No ☐

Preferred phone for follow-up discussion (e.g., test results):
Home ☐ Cell ☐ Work ☐

Spouse Information: Name:_____ Occupation: _____ Work Phone: ( ) _____	**Emergency Contact** (if other than spouse) Name: _____ Phone: ( )_____ Relationship: _____

Do you have medical insurance? Yes ☐ No ☐

Insurance: ID#: _____ Group #: _____ Are you the policy holder? Yes ☐ No ☐ If you are *not* the policy holder, provide the Policy Holder's Name: _____ Policy Holder's Birthdate: _____	**Medicare:** Are you covered by Medicare? Yes ☐ No ☐ If yes, is Medicare: Primary ☐ or Secondary ☐ ID#: _____

I authorize the release of any medical information necessary to process this claim and I authorize payment of medical benefits to physician for services rendered.

Signature:	**Date:**