Acct. #

PHILIP BRETSKY
MD | PHD

INTERNAL MEDICINE

Today's date / /

Last name: First: MI:

Home Address: Gender: M F

(No P.O. Boxes Accepted)

■ **Hm. ph.**( )

City: State: Zip: ■ **Wk. ph.**( )

Date of birth: / / Age ■ **Cell. ph.**( )

SSN: - - E-Mail:

Driv. lic. # State **Please preferred**

Occupation: **contact number above.**

Employer Info: Name:

Address: State Zip

Marital/Union status: M S D W Spouse's name

Emerg, contact: Relation Phone( )

Emerg. contact #2 Relation Phone( )

Please select one:

Race: ■ American Indian / Alaska Native ■ Asian ■ Black/African American

■ Native Hawaiian/Pacific Islander ■ Hispanic or Latino ■ White ■ Other Race

■ Unknown ■ Declined

How did you hear about us? ■ Friend/Relative: ■ Other

■ Internet ■ Another Physician:

I authorize Dr. Bretsky to bill my insurance company and/or Medicare and assign benefits payable to him. I understand that some services (even necessary, routine or preventative measures) may or may not be covered by my policy and that I will be financially responsible for these services *if* deemed unpayable by my insurance carrier. Should, after Dr. Bretsky's due diligence, my insurance company fail to pay within 90 days, I will assume full responsibility for any balance.

PATIENT OR RESPONSIBLE PARTY SIGNATURE:____

I hereby acknowledge that I have been presented with a copy of this office's Notice of Privacy Practices. I can receive a copy of this notice upon request.

SIGNATURE:____________________________________ **DATE:**__________________