TARRYTOWN FUNCTIONAL MEDICINE

Jill Fetell M. D. 13-15 Neperan Rd. Tarrytown, New York 10591
(914) 631-7911 www.tfmhealth.com Jillfetell@gmail.com

PRINT ABOVE LINE

FIRST NAME LAST NAME INITIAL E-MAIL

ADDRESS APT# CITY STATE ZIP CODE

MARRIED: YES__ NO__ M__F __ SOCIAL SEC. #_____ AGE_____

HOME PHONE (___)_____ WORK (___)_____ CELL (___)_____BIRTHDATE_____

NAME EMPLOYER ADDRESS YOUR OCCUPATION EMPLOYER

INSURANCE #1

INSURANCE NAME ADDRESS TELEPHONE#

INSURANCE ID# CATEGORY# GROUP#

INSURED NAME INSURED BIRTHDATE RELATION TO PATIENT

INSURED EMPLOYER ADDRESS WORK PHONE

INSURANCE #2

INSURANCE NAME ADDRESS TELEPHONE#

INSURANCE ID# CATEGORY# GROUP#

INSURED NAME INSURED BIRTHDATE RELATION TO PATIENT

INSURED EMPLOYER ADDRESS WORK PHONE

PHARMACY NAME ADDRESS TELEPHONE

IN CASE OF EMERGENCY NOTIFY RELATION TO PATIENT HOME PHONE WORK PHONE

ADDRESS APT# CITY STATE ZIP CODE

REFERRED BY **TELEPHONE#**

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICAL BENEFITS BE MADE ON MY BEHALF TO DR. JILL FETELL FOR ANY SERVICES FURNISHED TO ME BY THAT PHYSICIAN. I AUTHIRIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE IT TO MY INSURANCE COMPANY AS NEEDED TO DETERMINE BENEFITS PAYABLE FOR RELATED SERVICES. I AGREE TO BE RESPONSIBLE TO PAY THE CHARGES FOR MY TREATMENTS AND SERVICES AT TARRYTOWN FUNCTIONAL MEDICINE.

PATIENT'S SIGNATURE_____

DATE_____

INSURANCE CHECKING INFORMATION

AMOUNT OF DEDUCTIBLE_____
INSUR_____YEAR_____ COVERED_____
INSUR_____YEAR_____ COVERED_____
INSUR_____YEAR_____COVERED_____
OUT OF NETWORK YES_____ NO