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# Welcome

Please take the time to print clearly and fill in all the blanks so we may better serve you.

## Patient Information

Name \_\_\_\_\_ Maiden \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

S.S.# \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Sex (M) \_\_\_\_\_ (F) \_\_\_\_\_

Race \_\_\_\_\_ Marital Status: Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_

Legal Guardian \_\_\_\_\_ Relationship \_\_\_\_\_

Referring Physician \_\_\_\_\_ Family Physician \_\_\_\_\_

## Employment Information

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

## Primary Insurance Carrier

Company \_\_\_\_\_ ID# \_\_\_\_\_

Policy Holder \_\_\_\_\_ Birth Date \_\_\_\_\_

Employer \_\_\_\_\_ Group # \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

## Secondary Insurance Carrier

Company \_\_\_\_\_ ID# \_\_\_\_\_

Policy Holder \_\_\_\_\_ Birth Date \_\_\_\_\_

Employer \_\_\_\_\_ Group # \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

## Third Insurance Carrier

Company \_\_\_\_\_ ID# \_\_\_\_\_

Policy Holder \_\_\_\_\_ Birth Date \_\_\_\_\_

Employer \_\_\_\_\_ Group # \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

## Emergency Notification

Spouse \_\_\_\_\_ Work Phone \_\_\_\_\_

(Please also give someone outside your home.)

Name \_\_\_\_\_ Phone \_\_\_\_\_

Relationship \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

(If child does not live with both parents - Please give complete information on both households to front desk.)