greenwich adolescent medicine

Marcie Schneider, MD, FAAP, FSAHM
Sara Buchdahl Levine, MD, MPH, FAAP
239 Glenville Road Greenwich, CT 06831
Ph (203) 532-1919 Fax (203) 532-1518
www.greenwichadolescentmedicine.com

Patient Information

Patient: Name: _____ Date of Birth: _____

Address: _____ Home Phone: _____

_____ **Patient's** Cell Phone: _____

_____ **Patient's** E-mail: _____

Parents: Full Names: _____ _____

Work Phone: _____ _____

Cell Phone: _____ _____

Fax: _____ _____

Email: _____ _____

Address: _____ _____

Person Responsible for bills: _____ **Relationship to patient:** _____

Address/Phone Number if different than above: _____

By whom were you referred, or how did you hear of us?

_____

For what purpose are you seeing us? (Primary care, eating disorder, obesity, gynecology, or other issues?)

_____

If Applicable:

Primary Physician & Address: _____

Telephone: _____ Fax: _____

Other Provider (therapist, dietician, etc.): _____

Telephone: _____ Fax: _____

Other Provider (therapist, dietician, etc.): _____

Telephone: _____ Fax: _____

Billing Information:

In the event that you do not provide 24 hour notice for changes or cancellations of appointments (exceptions may be made in the event of an emergency), you will be billed for a portion of your appointment time. **You must provide us in advance with credit card information (Visa, MasterCard, or American Express) to cover any such charges.** If you would also like us to bill this account for other visits, please let us know. Your signature represents that you accept this policy. We appreciate your understanding.

Signature of parent/person responsible for bills: _____ Date: _____