JANET LEE, MD, JD
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NEW PATIENT INFORMATION FORM

Last Name: ________________________ First Name: ________________________

Preference (please circle one): Mr. / Mrs. / Ms. / Dr. / Other (_______)

Date of Birth: ___/____/_____

Home Address: ____
____

Home Phone: _________________________
Cell Phone: ___________________________
Work Phone: __________________________

Preferred Phone Number (please circle one): Home / Cell / Work

Email Address: __________________________

Name of Emergency Contact: ___________________________________
Relationship: ____
Phone Number: ____

Name of Pharmacy: ____
Address: ____
Phone Number: ____

Primary Care Physician: ____
Phone Number: ____

Insurance Company: ____
Name of Policy Holder: ____
Policy Number: ____

Do you have Medicare? Yes / No (please circle one)

Please note that Dr. Lee has opted out of Medicare. If you have Medicare and wish to see Dr. Lee, you must sign a separate agreement stating that you will not submit claims to Medicare.

_________________________ _______________
Signature Date