Lillian Trexler, M.D.
1611 116 Ave. NE #201
Bellevue, WA 98004

Patient Information Sheet

Patient Information (please print)

Name _____ Birth date ____/____/_____

Address _____ Marital Status: _____ Sex: M F Age _____

City _____ State _____ Zip _____ Home Phone _____

Employer _____ Occupation _____ Work Phone _____

Social Security Number _____ Cell Phone _____

Responsible Party (If same as patient skip to next section)

Name _____ Sex: M F Birth date ____/____/_____

Address _____ Phone: _____

Relationship to patient _____ Social Security No. _____

Insurance Information

Primary Insurance _____ Secondary Insurance: _____

Group number: _____ Group number: _____

Subscriber No.: _____ Subscriber No: _____

Ins. Co. Phone No.: _____ Ins. Co. Phone No.: _____

Emergency Contact (Not residing with you)

Name _____ Home Phone: _____

Address: _____ Work Phone: _____

Relationship to patient: _____

I hereby assign payment of authorized benefits to which I am entitled to be made directly to Dr. Trexler for services she provides to me. I authorized any holder of medical information about me to release any information needed to determine if these benefits are payable for related services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am responsible for all charges not paid for by insurance. I hereby authorize Dr. Trexler to release all information necessary to secure payment.

Signature._____ Date: _____