PANDORA E. CHRISTIE, MD
Patient Information

Name ______________________________ Date of Birth ____________ Age ________

Sex: ☐ Male ☐ Female Social Security # ______________________

Address: ______________________ City ______________ Zip ________

Home Phone ( ) ____________ Employer ______________ Work Phone ( ) __________
May we call/leave message: ☐ yes ☐ no May we call/leave message: ☐ yes ☐ no

IF A CHILD (under 18 years of age- Parent must sign at bottom of form):

Mother's name ____________ Home phone ( ) ____________ Work Phone ( ) __________

Father's name ____________ Home phone ( ) ____________ Work Phone ( ) __________

Referring Physician

Referring Physician ______________________ Address ______________________

Phone ( ) ______________ May we send a letter: ☐ yes ☐ no

Primary Care Physician ______________________ Address ______________________

Phone ( ) ______________ May we send a letter: ☐ yes ☐ no

Insurance Subscriber (if different from above)

Is this job related: ☐ yes ☐ no (Dr. Christie is not an L & I provider)

PRIMARY INSURANCE

Insurance Name ______________________

Subscriber Name ______________________

Subscriber Birthdate ______________________

Subscriber Employer ______________________

ID # ______________ Group # ____________

Relationship to patient ______________________

SECONDARY INSURANCE

Insurance Name ______________________

Subscriber Name ______________________

Subscriber Birthdate ______________________

Subscriber Employer ______________________

ID # ______________ Group # ____________

Relationship to patient ______________________

Person not living with you to notify in case of emergency:

Name ______________________________ Relationship to patient ______________

Address ______________________ City ______________ State ________ Zip ________

Home phone ( ) ______________________ Work phone ( ) ______________________

Release and Assignment: I hereby authorize the provider/insurance company to release any information required to process my medical claims. I also authorize my insurance benefits be paid directly to Pandora E. Christie, MD., PLLC. I will be responsible for any balance due not paid by my insurance.

Signature ______________________________________ Date ______________

Above information is current:
Signature ______________________________________ Date ______________