New Patient Intake Form
James Gronemeyer, DO
290 Massachusetts Avenue
Arlington, MA 02474

Name____Social Security #______________
Last First MI
Address____
____Zip___________
Phone__________________________Cell_____________________Work______________

Date of Birth---Gender: M F
Responsible
Person____
(If different from patient)____
Address____
Phone___________________________Work Phone________________________________
Relationship____
Referred
By____
Pharmacy Name and Number____

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Insurance Information:

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Medicare____
Blue Cross/Blue Shield____
Other---
Subscriber_________________________________Relationship____________________

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Medical Information, Payment Authorization and Office Policies

I understand and voluntarily give my authorization and consent to medical care by
James Gronemeyer, DO.

I certify that my condition is **not** an injury related to my work and is not a workers compensation case.

Emergency services are not available.

Office hours are by appointment only and we do enforce a 24 hour cancellation policy!

Payment is requested at the time service is provided.

Patient Or Guardian____Date__________________________