SILVERBLATT MEDICAL ASSOCIATES

The Center for Health and Longevity
8224 Mentor Avenue Suite #146
Mentor, OH 44060
Phone: (440) 290-8122
Fax: (440) 290-8051

Patient Information Date___________________

LAST NAME:_____________________ **FIRST NAME:**___________________ **MI**_____
HOME PHONE:____________________ **CELL PHONE:**____________________
ADDRESS:____
CITY:______________________ **STATE:**__________ **ZIP CODE:**_____________
Male / Female **BIRTHDATE:**__/__/____ **SOCIAL SECURITY #:**___ __ ____
Marital Status: Married Single Widowed Divorced

PHARMACY NAME:____________________________________
PHONE:___________________________

OCCUPATION:____
EMPLOYER:____
ADDRESS:____
CITY:______________________ **STATE:**_________ **ZIP CODE**_______________
WORK PHONE:_____________________
EMAIL:____________________________

ETHNICITY: Hispanic Non-Hispanic Decline
RACE: Black White Asian Hispanic Other Decline

In the event of an Emergency, who may we contact?

NAME:____
PHONE NUMBER:_________________________________

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I authorize **SILVERBLATT MEDICAL ASSOCIATES** to file claims to my insurance company. I also authorize **SILVERBLATT MEDICAL ASSOCIATES** to release medical information necessary to process my claims. I understand that I will be financially responsible for ALL payments including co-payments at the time of service.

SIGNATURE:_______________________________________ **DATE:**____________