THOMAS E. LIPIN, M.D.
210 JUPITER LAKES BLVD. SUITE 3-202
JUPITER, FL 33458 (561)746-2114

Date_____Patient's E-mail_____

Name_____
(Last) (First) (MI)

Social Security #_____Date of Birth_____

Local
Address_____
(# And Street) (City & Zip)
Northern
Address_____
(# And Street) (City & Zip)

Responsible Party:
(If patient is a minor) _____

Home Phone_____Work Phone_____

Cell Phone_____Name of Employer_____

Marital Status: S M D W Sex: M F Race: _____

Primary Physician_____

Referral Source_____

List All Medications_____

_____

_____

Please List any Allergies_____

Pharmacy You Wish To Use_____Phone#_____

Authorization and Release: I hereby authorize Dr. Lipin and/or his medical staff to release my medical information, including the diagnosis and records of any treatment or examination done in this office or other healthcare facility to third party payers and/or other health practitioners. I authorize my insurance to pay the doctor directly for his service when a claim has been filed with my insurance company. I understand that my carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services by Dr. Lipin for my dependants and myself. In the event I do not fulfill my financial obligation to Dr. Lipin, I will incur the 30% collection fee that will be added to any outstanding bill. All deductable and co-pays are required to be paid at the time of service. All cancellations must be made with in 24 hours notice or I will pay the missed appointment fee.

Signature_____Date_____