Julia Eilenberg, M.D.
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New Patient Information/Financial Agreement

Name: _____

Date of Birth: _____

Address: _____

_____

_____

Phone: (Please indicate primary confidential number by *)

Home: _____ Mobile: _____Work: _____

Emergency contact: Name: _____ Phone : _____

Primary care physician, Name of Practice, Telephone number:

_____

Name of family member responsible for payment: (If not self):

_____ D.O.B:_____

Address: _____ Phone:_____

_____

_____

Please note and sign below: Patient agrees to all policies regarding fees and collection of unpaid balance as described by Dr. Eilenberg. (See website for full description of policies.) Appointments cancelled with less than 48-hour notice will be charged in full.

_____
Signature of Patient and/or Financial Representative
(A copy of signed agreement available upon request.)