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First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ M.I. \_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

I am a : Female \_\_\_\_ Male \_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Preference? \_\_\_\_ Home \_\_\_\_ Cell

May We Leave Messages? YES \_\_\_\_ NO \_\_\_\_ SS#: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Single \_\_ Married \_\_ Divorced \_\_ Widowed \_\_

Language \_\_\_\_\_ Race \_\_\_\_\_ Ethnicity \_\_\_\_\_

Employer: \_\_\_\_\_ Position: \_\_\_\_\_ Employer Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Primary Doctor: \_\_\_\_\_ Referring Doctor: \_\_\_\_\_

Your Pharmacy: \_\_\_\_\_ Address and phone # \_\_\_\_\_

Do you have any allergies ? (If yes, please list) \_\_\_\_\_

**Spouse / Nearest Relative**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ M.I. \_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Female \_\_\_\_ Male \_\_\_\_ Relationship to you \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ SS#: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Parent \_\_\_\_ Spouse \_\_\_\_ Other \_\_\_\_

**Primary Insurance**

Insurance Company / Plan: \_\_\_\_\_ Insurance ID # \_\_\_\_\_

Person Carrying Insurance: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Secondary Insurance**

Insurance Company / Plan: \_\_\_\_\_ Insurance ID # \_\_\_\_\_

Person Carrying Insurance: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

**In Case of Emergency Please Notify**

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Relationship: \_\_\_\_\_

I hereby authorize the release of medical information concerning my examination and/or treatment, as needed to assign benefits. Also I authorize my insurance carrier to make payment directly to Robert S. Howe, M.D. I understand that I am fully responsible for payment of the balance of charges not paid by my medical insurance for services which I have received, including reasonable collection costs.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

How did you hear about us?? \_\_\_\_\_