Integrative Medical Center of New Mexico, PC

Burton M. Berkson, MD, PhD
Arthur J. Berkson, MD

Date: _____

Patient Information

Name_____ _____ _____
LAST FIRST MIDDLE

Address _____

City _____ State _____ Zip _____

Date of Birth _____/_____/_____ Social Security _____-_____-_____(Optional)

Home Phone _____ Wk Phone _____ Cell _____

Insurance Card Holder Information (If not the patient. For example, spouse or parent.)

Name_____ _____ _____
LAST FIRST MIDDLE

Address _____City _____ State _____ Zip _____

Date of Birth _____/_____/_____ Social Security _____-_____-_____ (Optional)

Home Phone _____ Wk Phone _____ Cell _____

Insurance information ***We MUST have a copy of your insurance card(s) AND please fill below.***

Primary Insurance _____ Name of Insured_____

ID # _____ Group # _____

Secondary Insurance _____ Name of Insured _____

ID # _____ Group # _____

Integrative Medical Center of N.M. does NOT ACCEPT ASSIGNMENT for insurance. However, we will process your insurance forms for you. ***(Please initial)*** **_____**

Emergency Contact

Name_____ _____ _____
LAST FIRST MIDDLE

Address _____City _____ State _____ Zip _____

Home Phone _____ Wk Phone _____ Cell _____

Medical Power of Attorney (if applicable. Please attach copy of Power of Attorney)

Name _____ Phone _____

(placement intentional due to chart structure)

Physician Name	Type (i.e. primary, oncologist)	Phone (include area code)
1.		
2.		
3.		
4.		
5.		
6.		