



PATIENT INFORMATION RECORD

Date: 06/05/2018

Medical Record Number #: [REDACTED]

Patient Name: EPSTEIN, JEFFREY

Social Security #: [REDACTED]

Address: 6100 RED HOOK QUARTERS

Apt/Unit/Suite: APT B3

City: SAINT THOMAS

State: VI

Zip: 00802

E-Mail:

Date of Birth: 01/20/1953

Primary Phone #: [REDACTED]

Please validate your referring physician and contact information by marking the check boxes below.

- Referring Physician: MOSKOWITZ, BRUCE W. M.D. M.D.
- Referring Physician's Address: 1411 NORTH FLAGLER DRIVE SUITE 7100 WEST PALM BEACH, FL 33401
- Referring Physician's Phone: [REDACTED]

Your referring Physician that has ordered this procedure will receive reports, films and/or CD (their preference). Please indicate by marking in the check box if you would like any additional processing to yourself or other physicians

Additional Physicians Name: _____ Address: _____

Additional Reports To: _____ Address: _____

- Report Only (No Charge)
- Report & CD (\$25.00)
- Report & Films (\$200.00)

Insurance Information

Insurance Company: UNITED HEALTHCARE

Group #: 272605

Insured's Name: JEFFREY EPSTEIN

Insured's DOB: JAN. 20, 1953

Insured's ID#: [REDACTED]

Relation to patient: SELF

Do you have supplemental/secondary insurance? Yes No

If yes, Insurance Company: _____ Insured's ID #: _____

Has your insurance changed since your last visit? Yes No

(if yes, please fill out insurance information above and supply your new insurance card(s) to the front desk receptionist.)

EXAMS TODAY

<u>Date / Time</u>	<u>Exam Code</u>	<u>Referring Name</u>	<u>Accession</u>
06/05/2018 8:30 AM EDT	MRCLAVL	MOSKOWITZ, BRUCE W, M.D	7156124

PAYMENT IS DUE AT THE TIME OF SERVICE

- Cash
- Check
- Mastercard
- Visa
- Amex
- Discover

I HEREBY ACKNOWLEDGE THAT I AM FULLY RESPONSIBLE FOR ANY UNPAID BALANCES.

Signature of Patient or Guardian: [Handwritten Signature]