MICHAEL KUTTNER, PH.D.

	PATIENT INFORMATION	
NAME (Last)	(First)	(Middle)
DATE OF BIRTH	Social Security #	
ADDRESS (Street)	(Town)	**NY** Zip
HOME PHONE	WORK PHONE	CELL PHONE
EMERGENCY CONTACT	PHONE NUMBER	EMPLOYER
PRIMARY CARE MD	Address	Phone #
REFERRING MD	Address	Phone
	INSURANCE INFORMATION	
PRIVATE INSURANCE		
Primary Insurance	**Insurance Purchaser: IF Spouse or Parent**	
Policy #	**Spouse/Parent Name:**	
Secondary Insurance	**Spouse/Parent Date of Birth:**	
Policy #	**Spouse/Parent Address:**	
WORKER'S COMPENSATION		
Insurance Co.	Date of Injury	WCB #
Address	Phone	CC #
Contact Person		Fax
MOTOR VEHICLE ACCIDENT		
Insurance Co:	Date of Accident:	Claim #
Address		NF#
Contact Person		
Phone	Fax	

I hereby authorize payment of medical benefits directly to Dr. Kuttner. I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the *INSURANCE AND FINANCIAL ARRANGEMENTS* information and have completed the above information. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information.

I understand that appointments missed with less than 24 hours notice will be billed directly to me.

I understand that payment is due at time of service. Bills 90 days past due are automatically sent to collection.

____ ___________________________

Signature Date

____ ___________________________

Parent (if minor) Date