ROMANICK MD PLLC
arthritis, fibromyalgia & immune disorders

<table>
<tr><th colspan="6">Personal Information</th></tr>
<tr><td colspan="2">Last name</td><td colspan="2">First Name</td><td colspan="2">MI</td></tr>
<tr><td colspan="6">Address</td></tr>
<tr><td colspan="4">City</td><td>State</td><td>Zip</td></tr>
<tr><td colspan="2">Home phone</td><td colspan="2">Cell</td><td colspan="2">Email</td></tr>
<tr><td>Date of Birth</td><td>Gender
M F</td><td colspan="2">Social Security Number</td><td colspan="2">Marital Status</td></tr>
<tr><td>Spouse's Name</td><td colspan="2">Employer (or student status)</td><td colspan="3">Work Phone</td></tr>
<tr><td>Allergies</td><td colspan="5">I give permission for test results to be left on/with: (circle where applicable)
Home phone Cell Spouse email other individual (specify):</td></tr>
</table>

<table>
<tr><th colspan="3">Insurance Information</th></tr>
<tr><td></td><td>Primary Insurance</td><td>Secondary Insurance</td></tr>
<tr><td>Insurance Name</td><td></td><td></td></tr>
<tr><td>Subscriber's Name</td><td></td><td></td></tr>
<tr><td>Subscriber's Birth Date and sex: M or F</td><td></td><td></td></tr>
<tr><td>Relationship to subscriber: child, spouse, self, other</td><td></td><td></td></tr>
<tr><td>Policy Number</td><td></td><td></td></tr>
<tr><td>Group, Member or Claim Number</td><td></td><td></td></tr>
<tr><td>Effective Date</td><td></td><td></td></tr>
<tr><td>Co-payment Amount</td><td></td><td></td></tr>
</table>

<table>
<tr><th colspan="3">Emergency Contact</th></tr>
<tr><td>Name</td><td>Relationship</td><td>Phone Number</td></tr>
</table>

Referred to this office by:

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance, including no show visits and late cancellations (a copy of the no show / cancellation policy is included in your new patient packet and is also available from the receptionist).

Patient Signature Date