Mark R. Fleckner M.D.P.C.
Vitreo-Retinal Specialist

520 Franklin Ave
Garden City NY 11530
Suite L-6
516-739-5905

61-34 188th Street
Fresh Meadows NY 11365
Suite 206
718-454-7700

PATIENT QUESTIONNAIRE

Patient Data:

LAST NAME | FIRST NAME | INITIAL | MALE/ FEMALE

SOCIAL SECURITY NUMBER | DATE OF BIRTH | MARITAL STATUS S__M__W__D__

ADDRESS | CITY | STATE | ZIP

HOME PHONE | WORK PHONE | CELL PHONE | FAX

IN CASE OF AN EMERGENCY CONTACT | NAME, ADDRESS AND RELATIONSHIP

PRIMARY PHYSICIAN | ADDRESS | PHONE NUMBER

REFERRING PHYSICIAN | ADDRESS | PHONE NUMBER

PHARMACY | ADDRESS | PHONE NUMBER

PRIMARY INSURANCE COMPANY NAME | ID NUMBER | CO-PAY

SECONDARY INSURANCE COMPANY NAME | ID NUMBER | CO-PAY

YOU MUST FILL THIS OUT IF PATIENT IS NOT THE INSURED :

RELATIONSHIP TO INSURED | NAME | ADDRESS | SOCIAL SECURITY NUMBER | DOB

PATIENT'S OR GUARDIAN'S SIGNATURE & DATE _____