WELCOME TO THE OFFICE OF

FREDRIC R MILLER, M.D., F.A.C.G.
20 West Lincoln Avenue, Suite 201
Valley Stream, New York 11580

TODAY'S DATE: _____ REFERRED BY:_____

Who is your Primary Care Physician (PCP)? _____

Last Name: _____ First Name_____ Middle Initial:___

Street Address:_____

City:_____ State:_____ Zip Code:_____

☐ ***Male*** ☐ ***Female***

Date of Birth: _____ Social Security #:_____

Home Telephone #: _____ Cell Phone #:_____

Email address: _____

Employer: _____

Marital Status: SINGLE___ MARRIED___ OTHER___

IN CASE OF AN EMERGENCY - CONTACT NAME/ TELEPHONE #:_____

~~INSURANCE INFORMATION~~

PRIMARY Insurance Company: _____

Address: _____Policy #:_____

Group #:_____Policy Holder's Name:_____ Relationship:_____

Policy Holder's DOB: _____

SECONDARY Insurance Company: _____

Address: _____ Policy #:_____

Group #:_____Policy Holder's Name:_____ Relationship:_____

Policy Holder's DOB: _____

~~PHARMACY INFORMATION~~

Name:_____ Address: _____ TEL: _____