

1. Health insurance Coverage Medicare <input checked="" type="checkbox"/> Medicaid <input type="checkbox"/> Group plan <input type="checkbox"/> Other <input type="checkbox"/>				2. Patient relationship to insured Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>				3. Insured's ID Number 1EG4TES																																																																																					
4. Patient's Name DARON YONDEM				5. Patient Birth date 01/01/1980		6. Insured's Birth Date																																																																																							
7. Street Address 2547 CAYNOR ST				8. City Somerville		9. State NJ																																																																																							
10. Zip Code 08876				11. Telephone 9085817518		12. Alternate Telephone																																																																																							
13. Is Patient's Condition Related to: <table style="width: 100%; border: none;"> <tr> <td style="width: 33%; border: none;"> a. Employment <input type="checkbox"/> Yes <input type="checkbox"/> No </td> <td style="width: 33%; border: none;"> b. Auto Accident <input type="checkbox"/> Yes <input type="checkbox"/> No </td> <td style="width: 33%; border: none;"> c. Other Accident <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No </td> </tr> </table>								a. Employment <input type="checkbox"/> Yes <input type="checkbox"/> No	b. Auto Accident <input type="checkbox"/> Yes <input type="checkbox"/> No	c. Other Accident <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No																																																																																			
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14. Diagnosis or nature of illness or injury <table style="width: 100%; border: none;"> <tr> <td style="width: 25%; border: none;">a. Anxiety</td> <td style="width: 25%; border: none;">b.</td> <td style="width: 25%; border: none;">c.</td> <td style="width: 25%; border: none;">d.</td> </tr> <tr> <td style="border: none;">e.</td> <td style="border: none;">f.</td> <td style="border: none;">g.</td> <td style="border: none;">h.</td> </tr> <tr> <td style="border: none;">i.</td> <td style="border: none;">j.</td> <td style="border: none;">k.</td> <td style="border: none;">l.</td> </tr> </table>								a. Anxiety	b.	c.	d.	e.	f.	g.	h.	i.	j.	k.	l.																																																																										
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15. Claims <table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <thead> <tr> <th rowspan="2"></th> <th colspan="6">Dates of Service</th> <th rowspan="2">Procedure, service or supplies Description</th> <th rowspan="2">Charges</th> <th rowspan="2">Amount Paid</th> </tr> <tr> <th colspan="2">FROM</th> <th colspan="4">TO</th> </tr> </thead> <tbody> <tr> <td>a.</td> <td>10</td><td>10</td><td>21</td><td>11</td><td>10</td><td>21</td> <td></td><td>1234</td><td>34</td> </tr> <tr><td>b.</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>c.</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>d.</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>e.</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>f.</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>g.</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> </tbody> </table>									Dates of Service						Procedure, service or supplies Description	Charges	Amount Paid	FROM		TO				a.	10	10	21	11	10	21		1234	34	b.										c.										d.										e.										f.										g.									
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