Advance Biomedical
Treatment Center

Eileen C. Comia, M.D.
35 Jolley Drive Suite 102
Bloomfield CT 06002
Tel (860)242-2200
Fax (860)242-2212
info@advbiomedtx.com

Please print legibly. All information will be kept confidential.

Today's Date: _____

Last Name: _____ First Name: _____ MI: ___

Birthdate: _____ Age: ____ M / F: ___ Social Security no. _____

Street Address: _____ Apt no. _____

City _____ State _____ Zip _____

Country _____ Email: _____

Home: (_____) _____ Cell: (_____) _____

PARENTS INFO (If patient is a minor, please complete.)

Father's Name: _____ Tel (____) _____

Address: _____

Occupation: _____

Mother's Name: _____ Tel (____) _____

Address: _____

Occupation: _____

EMERGENCY CONTACT (Other than the Parent)

Name: _____ Relation to Patient: _____

Tel: (____) _____ Email: _____

PATIENT INFO

Diagnosis / Date Diagnosed: _____

_____

_____

Medications: _____

_____

_____

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Please print legibly. All information will be kept confidential.

Allergies: Foods: _____

Medications: _____

Environmental: _____

Chemical: _____

Others: _____

Primary Care Physician: _____ Tel (_____) _____

Address: _____

I certify that the information on this form is true to the best of my knowledge. I accept responsibility for the medical charges incurred and agree to pay all bills at the time of service.

_____
Patient Printed Name

_____ _____
Patient Signature Date
(Parent/Legal Guardian if patient is a minor)