BrainCARE

Concussion ◆ Assessment ◆ Recovery ◆ Education

(MICHAEL LEWIS MD LLC)

(*Required)

CONTACT INFORMATION

Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐

First Name*

Middle Name/Initial

Last Name*

Company/School/Grade

Email Address*

Mobile Phone*

Office Phone

Home Phone

Fax

Appointment Reminder via Email ☐ or Text ☐

Referred By

Date of Birth*

Gender* Male ☐ Female ☐

EMERGENCY CONTACT

Name

Relationship

Phone

INSURANCE COMPANY

Payer ID

Name*

Phone

Fax

Address

Address(2)

City

State

Zip Code

ADDRESS

Address

City

State

Zip Code

PREFERRED PHARMACY

Pharmacy Name*

Phone

Fax

Address

City

State

Zip Code

INSURED PERSON DETAILS

Plan/Program Name

Employer/School

Group ID#

Subscriber ID#*

Insurance Type

Effective From (date)

Relationship to Patient

Insured's Name

Insured's Gender Male ☐ Female ☐

Insured's Date of Birth

Phone

Address

City

State

Zip Code

7811 Montrose Road Suite 215 Potomac, Maryland 20854 (240) 398-3481