

**Amy Huberman, MD**  
1501 Sulgrave Avenue, Suite 202  
Baltimore, MD 21209  
443-823-0675

**CONTACT INFORMATION**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Middle Initial: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_

Please check if the following are acceptable for communication and confidential messages:

\_\_\_\_\_ Home Phone

\_\_\_\_\_ Work Phone

\_\_\_\_\_ Cell Phone

\_\_\_\_\_ E-mail

If a minor, name of Guardian: \_\_\_\_\_

Relationship: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Relationship: \_\_\_\_\_

Emergency Contact Phone(s): \_\_\_\_\_

Referral Source: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Primary Care Physician Phone: \_\_\_\_\_ Last Visit: \_\_\_\_\_

Insurance: \_\_\_\_\_

Name of Insured: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Employer: \_\_\_\_\_

Position: \_\_\_\_\_

Phone number: \_\_\_\_\_

Address: \_\_\_\_\_

Do you have Medicare? Yes / No

*Dr. Huberman has opted out of Medicare; therefore, those individuals with Medicare who wish to see her cannot submit claims to Medicare and must sign an agreement stating an understanding of this.*

I understand that I am responsible for full payment at the time of service, that Dr. Huberman does not participate with any insurance company, and that I will be charged for phone appointments, any missed appointments, and appointments canceled within less than one full business day.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date