



MARK LEVENTER MD
KATHLEEN ANZICEK DO
DIANA PARKS CFNP

Grass Lake Medical

12337 E. Michigan Avenue
Grass Lake, MI 49240-9213
(517) 522-8403

PATIENT INFORMATION

NAME (Last, First Middle)				MRN	SSN#	BIRTHDATE	LANGUAGE	SEX
LOCAL ADDRESS		CITY, STATE ZIP		REFERRING PHYSICIAN		SECONDARY/BILLING ADDRESS (if Applicable)		
HOME PHONE	DAY PHONE	EMAIL ADDRESS		PRIMARY CARE PROVIDER		CITY, STATE ZIP		
MARITAL STATUS	STUDENT STATUS <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time	SMOKER (Y/N)?	VETERAN (Y/N)?	EMERGENCY CONTACT NAME		CONTACT PHONE	HOME PHONE	
PRIMARY EMPLOYER				SECONDARY EMPLOYER (if Applicable)				
ADDRESS				ADDRESS				
CITY, STATE ZIP				CITY, STATE ZIP				
WORK PHONE				WORK PHONE				

RESPONSIBLE PARTY INFORMATION (if Different than above)

NAME (Last, First Middle)				SSN#	BIRTHDATE	LANGUAGE	SEX
LOCAL ADDRESS		CITY, STATE ZIP		SECONDARY/BILLING ADDRESS (if Applicable)			
HOME PHONE	DAY PHONE	EMAIL ADDRESS		CITY, STATE ZIP			
MARITAL STATUS	STUDENT STATUS <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	SMOKER (Y/N)?	VETERAN (Y/N)?	PRIMARY CARE PROVIDER		HOME PHONE	
RELATIONSHIP TO PATIENT							

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY			POLICY#		
NAME OF INSURED			GROUP#		
ADDRESS OF INSURANCE COMPANY			COPAY AMT \$		
CITY, STATE ZIP		PHONE	DEDUCTIBLE \$		
RELATIONSHIP TO PATIENT			EFFECTIVE DATE	EXPIRATION DATE	

SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY			POLICY#		
NAME OF INSURED			GROUP#		
ADDRESS OF INSURANCE COMPANY			COPAY AMT \$		
CITY, STATE ZIP		PHONE	DEDUCTIBLE \$		
RELATIONSHIP TO PATIENT			EFFECTIVE DATE	EXPIRATION DATE	

I authorize my insurance carrier to make payment directly to Mark Leventer, M.D. or Kathleen Anzicek, D.O., for services provided. In the event that my insurance carrier does not pay for services rendered, I will be responsible for the amount due. I authorize the release of any medical information needed to determine these benefits or the benefits payable for related services. I will be responsible for any fees incurred in the event my account becomes delinquent and the Grass Lake Medical Center is forced to place my account into collections.

SIGNATURE OF PATIENT/GUARDIAN

DATE