BAYSIDE FAMILY MEDICINE
510 Cranberry Street, Suite 200
Erie, PA 16507
P) 814-877-5274 F) 814-877-5882

Dr. Pamela Morey, DO
Dr. Albert Charron, MD

Last Name ____________ First Name ____________ MI ____ Birth date ____________
Address ______________________ City ____________ State ____ Zip ______
Phone - Home ________________ Cell ________________
SS# ________________ Sex: Male / Female Marital Status: S M D W
Spouse Name ______________________ Phone ____________
Next of Kin ______________________ Phone ____________
Employer ______________________ Work ____________ ext. ______
Full Time/Part Time ________ Job Description ________________
(Optional) Race: Caucasian, African American, Hispanic, Native American, Other ____________

Referred by ______________________________

Primary Insurance Company Name: ______________________
Policy or ID #: ________________ Group or Plan #: ________________
Insured's Last Name ____________ First Name ____________ Birthdate ________
Employer Name ________________ Phone #: ____________
SS# ________________ Address: ________________
____

Secondary Insurance Company Name: ______________________
Policy or ID #: ________________ Group or Plan #: ________________
Insured's Last Name ____________ First Name ____________ Birthdate ________
Employer Name ________________ Phone #: ____________
SS# ________________ Address: ________________
____

I authorize the release of medical information to my insurance carrier and authorize the payment of medical benefits directly to my physician.

Signed: ____________________ Date: ________ Witness: ____________