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LEGAL NAME: _____ **AGE:** _____

ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

DATE OF BIRTH: _____ **SEX:** _____ **MARITAL STATUS:** _____ **Preferred Pronouns:** _____
(optional)

ETHNICITY: _____ **RACE**: _____

LANGUAGE SPOKEN: English Other: _____

Preferred Phone #: _____ **Can this number receive SMS messages? Y N**

EMAIL: _____

EMPLOYER: _____ **WORK#:** _____

NAME OF EMERGENCY CONTACT: _____

RELATIONSHIP TO PATIENT: _____ **PHONE#:** _____

IS IT OK TO DISCUSS YOUR CARE? Y N IS IT OK TO LEAVE DETAILED VOICE MAIL? Y N

PHARMACY NAME & PHONE NUMBER: _____

REFERRING PHYSICIAN: _____

PRIMARY CARE DR NAME: _____

INSURANCE COMPANY: _____

ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

SUBSCRIBER ID# / POLICY#: _____ **SUBSCRIBER NAME & DOB:** _____
GROUP#: _____

PERSON WHO CARRIES INSURANCE: _____ **RELATIONSHIP TO PATIENT:** _____

I HEREBY ASSIGN TO THE PROVDER WHOSE NAME APPEARS ABOVE ALL BENEFITS FOR MEDICAL AND/OR SURGICAL EXPENSES. I AGREE TO PAY ANY AND ALL CHARGES THAT EXCEED OR THAT ARE NOT COVERED BY INSURANCE. I AUTHORIZE THE PROVIDER NAMED ABOVE TO RELEASE ANY MEDICAL RECORDS REQUESTED BY MY INSURANCE CARRIER. I ALSO AUTHORIZE ANY HEALTHCARE PROVIDER TO RELEASE MEDICAL INFORMATION PERTAINING TO ME TO THE PROVIDER NAMED ABOVE, IN ADDITION I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION TO ANY PROVIDER, I AM REFERRED TO BY THIS OFFICE. I AGREE TO PAY ANY CO PAYMENTS DUE FROM NY INSURANCE AT THE TIME OF MY VISIT.

SIGNATURE: _____ **DATE:** _____