Patient Information:

Last Name_____ First Name_____ DOB _____

Street Address_____ Apt. #_____ Last four digits of SS _____

City_____ State _____ Zip _____

Marital Status: __Single __Married __Divorced (1) Home Phone _____

(2)Cell Phone_____ (3)Work Phone_____ Indicate Primary contact #:_____

E-mail Address_____

Patient's Employer Information:

Employer Name_____ Employer Phone _____

Employer Address_____
Street City State Zip

Occupation:_____ If Student ___Full time ___Part time School _____

Insurance Information–Primary/Secondary/Other **Do you have health insurance? ___Yes ___No**

Primary Insurance _____ Copy of Card? ____Yes ____No

Subscriber_____ DOB _____ Relationship_____

Secondary Insurance_____ _____Copy of Card? ____Yes ____No

Subscriber_____ DOB_____ Relationship_____

Emergency Information: ***MUST BE COMPLETED*** (e.g. nearest relative preferably not living with you)

In case of an emergency/urgent matter we may contact: _____

_____ _____

Telephone Number Relationship to Patient

Other:

Primary Care Physician: _____ Phone # _____

Referring Physician: _____ Phone # _____

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Authorization for Treatment, Payment & Healthcare Operations

I authorize the release of my medical information for purposes of treatment, payment and healthcare operations. Additionally, I authorize and assign any payment of medical benefits to Endocrine Associates of Nassau & Queens, P.C., its successors and assigns, or any individual it may designate for services provided.

As part of this authorization, Endocrine Associates of Nassau & Queens, P.C. will release HIV, drugs and Alcohol, and Mental Health/Psychiatric information as required by law unless otherwise indicated. I understand that I have the right to request that services for which I have paid out-of-pocket, not be disclosed to my health plan.

I agree to pay interest at the prevailing rates for 30 days past due, as well as costs including attorney's fees, associated with the collection of any amounts due for services rendered. I understand that I am financially responsible to Endocrine Associates of Nassau & Queens, P.C., it successors and assigns or any individual it may designate, for amounts owed by me in accordance with my health benefit coverage. I acknowledge that I will be responsible for all unpaid claims if I fail to provide insurance information within my health plan's filing limit for services rendered.

_____ _____

Signature of Patient or Parent of Minor Date

Medicare Authorization for Treatment, Payment & Healthcare Operations, Medicare Recipients Sign both Authorizations

I authorize the release of my medical information for purposes of treatment, payment and healthcare operations. I request that payment of Authorized Medicare benefits be made either to me or on my behalf to Endocrine Associates of Nassau & Queens, P.C. for services furnished to me by the providers. I authorize any holder of my medical information to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine benefits for related services rendered.

_____ _____

Patient's Signature Date