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CHIEF COMPLAINT(S)

PATIENT INFORMATION

NYH #: _____ DATE: _____ DOB: _____ AGE: ___ SEX: __Male __Female
MARITAL STATUS: __Single __Married __Widowed __Separated __Divorced

FULL NAME: _____
HOME ADDRESS: _____
_____
_____

SS #_____-____-_____Home Phone: ( )_____-_____ Work Phone: ( )_____-_____
***Cell Phone* : ( )_____-_____**
Where were you born? _____ City _____ State _____Country
Occupation: _____ Where you ever admitted to NYPH? : __ YES __NO
If no, what are your parent's first names? _____Mother _____Father
REFERRING PHYSICIAN & HOSPITAL: _____
ADDRESS: _____
PHONE: _____

NAME OF PERSON TO NOTIFY IN CASE OF EMERGENCY: _____
Relationship: _____ Emergency Phone: ( )_____-_____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____
ADDRESS: _____
ID#: _____ GROUP #: _____
EFF DATES: _____ Phone #: ( )_____-_____
SUBSCRIBERS NAME:_____ SS #: _____-___-_____
SUBSCRIBER's RELATIONSHIP TO PATIENT: __Self __Spouse ____Other,
Specialist Copay _$_____

SECONDARY INSURANCE: _____
ADDRESS: _____
_____
GROUP #: _____ EFF DATES: _____ Phone #: ( )_____-_____
SUBSCRIBERS NAME:_____ SS #: _____-_____-_____
SUBSCRIBERS RELATIONSHIP TO PATIENT: _Self _Spouse _ Other
Specialist Copay _$_____

I authorize any holder of medical information about me to release to the Social Security Administration and Health Care Financing Administrator or its intermediaries or carriers, or to my insurance carrier, any information needed for this or other medical insurance claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to myself or to the party who accepts assignment. I certify that all information above is true and correct. I understand that I am responsible for any bills generated from the services rendered.

Accept assignment? __Yes __No
Signature of responsible party_____
Relationship _____ Date_____