PRECISION MEDICAL ARTS OF NEW YORK, PLLC

DATE_____

PATIENT INFORMATION

NAME_____

ADDRESS _____

CITY_____STATE_____ZIP_____

CELL_____HOME_____

EMERGENCY CONTACT

NAME_____

ADDRESS _____

CITY_____STATE_____ZIP_____

CELL_____HOME_____

DATE OF BIRTH: _____ GENDER____M____F

EMAIL_____

SOCIAL SECURITY NUMBER _____-_____-_____

MARITAL STATUS: S M W D

EMPLOYER NAME AND ADDRESS _____

_____ WORK PHONE_____

WHERE DID YOUR INJURY OCCUR: HOME, SCHOOL, WORK, CAR ACCIDENT, SPORTS, OTHER_____

DATE OF INJURY OR ACCIDENT: _____ REPORT FILED/WITH WHOM_____

PAYMENT INFORMATION

PRIMARY INSURANCE

NAME_____

ID#_____

POLICY HOLDER_____

SECONDARY INSURANCE

NAME_____

ID#_____

POLICY HOLDER_____

I AUTHORIZE THE PHYSICIANS OF PRECISION MEDICAL ARTS OF NEW YORK, PLLC TO RELEASE MY MEDICAL INFORMATION TO MY INSURANCE COMPANY FOR PAYMENT OF MY CLAIMS. I AUTHORIZE MY INSURANCE COMPANY TO PAY THE PHYSICIAN DIRECTLY AND I UNDERSTAND I AM RESPONSIBLE TO FORWARD ANY PAYMENTS TO MY PHYSICIAN. I UNDERSTAND I AM RESPONSIBLE FOR ANY FINANCIAL OBLIGATIONS AND ANY SERVICES NOT COVERED BY INSURANCE.

NAME_____

SIGNATURE_____

PRECISION MEDICAL ARTS OF NEW YORK, PLLC

PATIENT NAME _____

PRIMARY CARE PHYSICIAN_____ PHONE_____

ADDRESS: _____

SPECIALISTS: _____

WHO MAY WE THANK FOR REFERRING YOU?_____

REASON FOR VISIT: _____

LIST ALL MEDICAL CONDITIONS: _____

_____

PREVIOUS SURGERY: _____

_____

MEDICATIONS: _____

_____

ALLERGIES: _____

HEIGHT: _____ WEIGHT: _____

PRIMARY LANGUAGE: ENGLISH, SPANISH, OTHER_____

RACE: AMERICAN INDIAN, ASIAN, AFRICAN AMERICAN, CAUCASIAN, OTHER_____

SMOKER: Y N HOW MUCH DO YOU SMOKE? _____ FOR HOW LONG? _____

PHARMACY

NAME_____ PHONE_____

ADDRESS: _____

NAME_____ **SIGNATURE**_____