



1220 New Scotland Rd., Slingerlands, NY 12159 518-439-4326

Account # _____

Patient Name: _____ Male: _____ Female: _____
 Address: _____ Social Security #: _____
 City: _____ State: _____ Zip: _____ Date of Birth: _____ Age: _____
 Home Phone: _____ Cell Phone: _____ Work Phone: _____
 Email address: _____ Marital Status: S/M/D/W _____
 Primary Care Physician: _____ Phone #: _____
 Referring Physician: _____ Phone #: _____
 Pharmacy Name: _____ Phone #: _____
 Employer Name & Phone #: _____
 Employer Address: _____
 Emergency Contact: _____ Phone #: _____
 How did you hear about us?
 TV ad Newspaper Friend/Relative
 Website Physician Other

PRIMARY INSURANCE: _____ Co-pay amount: _____
 Address: _____ Referral Needed: Y N

Member ID #: _____
 Policy Holders Name: _____ Social Security #: _____
 Policy Holders Address: _____ Date of Birth: _____
 Insurance Group #: _____ Relation to Patient: Self Spouse Child Other
 Policy Holders Employer: _____ If retired - Date: _____
 Employers Address: _____ Phone #: _____

SECONDARY INSURANCE: _____ Co-pay amount: _____
 Address: _____ Referral Needed: Y N

Member ID #: _____
 Policy Holders Name: _____ Social Security #: _____
 Policy Holders Address: _____ Date of Birth: _____
 Insurance Group #: _____ Relation to Patient: Self Spouse Child Other
 Policy Holders Employer: _____ If retired - Date: _____
 Employers Address: _____ Phone #: _____

WORKERS COMPENSATION INSURANCE CO.: _____

Address: _____ Phone #: _____
 Date of Injury: _____
 Employer at time of injury: _____ Carrier Case#: _____
 Employer Address: _____ WCB#: _____
 Currently Working?: Yes No If no, date stopped: _____ Ins. Contact: _____

NO FAULT INSURANCE: _____ Phone #: _____
 Address _____ Date of Injury: _____
 Claim #: _____

Policy Holder Name: _____ Policy #: _____
 Currently Working?: Yes No If no, date stopped: _____ Ins. Contact: _____

I authorize the release of any medical information necessary to process insurance claims, and the release of information back to my physician. I also authorize payment of medial benefits to the above state physician. Supplier, for services rendered.

SIGNATURE: _____ Date: _____