

PATIENT INFORMATION

Last name	First name	M.I.	Date of birth (MM/DD/YYYY)
Sex	Social Security #	Marital status	
☐ Male ☐ Female ☐ X		☐ Single ☐ Married ☐ Divorced ☐ Widowed	
Street address	Apt / Suite		
City	State	ZIP	
Cell phone	Home / other phone	Email	
Preferred language	Preferred contact		
	☐ Cell ☐ Text ☐ Email ☐ Home		
Employer	Occupation		

EMERGENCY CONTACT

Full name	Relationship	Phone

REFERRING & PRIMARY CARE PHYSICIANS

Referring physician	Practice / hospital	Phone
Primary care physician	Practice	Phone

PRIMARY INSURANCE

Insurance company / plan name	Insurance phone		
Member / Subscriber ID	Group #	Effective date	
Policyholder name (if not patient)	Policyholder DOB	Relationship to patient	
		☐ Self ☐ Spouse ☐ Child ☐ Other	

SECONDARY INSURANCE (IF ANY)

Insurance company / plan name	Insurance phone		
Member / Subscriber ID	Group #	Effective date	
Policyholder name (if not patient)	Policyholder DOB	Relationship to patient	
		☐ Self ☐ Spouse ☐ Child ☐ Other	

RESPONSIBLE PARTY (ONLY IF SOMEONE OTHER THAN THE PATIENT PAYS)

Full name

Relationship to patient

Date of birth

Phone

Address (street, city, state, ZIP)

VISIT & HEALTH INFORMATION

Reason for visit

Drug allergies (and reaction)

Current medications (name, dose, how often)

Preferred pharmacy

Pharmacy address / cross streets

Pharmacy phone

CONSENTS & AUTHORIZATIONS

Consent to treatment. I consent to examination, diagnostic testing and treatment by Mark N. Sayegh, MD and staff of New York Infectious Disease & Public Health Medicine, P.C., including services provided in the office, hospital or other facility, as deemed medically necessary.

Assignment of benefits. I assign to the practice all insurance benefits otherwise payable to me for services rendered, and authorize my insurer(s), including Medicare and Medicaid, to pay the practice directly.

Release of information. I authorize the practice to release medical and billing information to my insurance carrier(s), their agents, and the practice's billing service as needed to process claims, and to communicate with my referring and primary care physicians about my care.

Financial responsibility. I understand I am responsible for copays, coinsurance, deductibles, and any charges not covered by my insurance, including services my plan deems non-covered or out-of-network, as permitted by law. I agree to notify the practice of any change in my insurance.

Notice of Privacy Practices. I acknowledge that I have been offered a copy of the practice's Notice of Privacy Practices (HIPAA), which explains how my health information may be used and disclosed.

By signing below, I confirm the information on this form is accurate and agree to the statements above.

Patient (or legal representative) signature

Date

Printed name

If signed by representative, relationship to patient

FOR OFFICE USE ONLY

Photo ID verified []

Ins. card copied []

Eligibility checked []

Entered by: _____

Date: _____