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2 TELEPORT DRIVE, Suite 207 • STATEN ISLAND, NY 10311

PATIENT DEMOGRAPHICS

NAME ______________________________ DATE ____/____/____
LAST FIRST MI

DATE OF BIRTH ____/____/____ SS# [| | | | | | | |] MARITAL STATUS: ☐ S ☐ M ☐ W ☐ D ☐ SEP

ETHNIC BACKGROUND ______________ RELIGION ______________

ADDRESS ______________________________ [|] [| | | |]
STREET CITY STATE ZIP CODE

CONTACT INFO (____) ____–______ (____) ____–______ (____) ____–______
HOME PHONE # CELL PHONE # WORK PHONE #

E-MAIL: ______________________________

OCCUPATION ______________ EMPLOYER ______________

PRIMARY DOCTOR ______________________________ (____) ____–______
NAME PHONE#

REFERRED BY: ______________________________

PREFERRED PHARMACY:

______________________________ (____) ____–______
PHONE #

____
ADDRESS

PATIENT INSURANCE INFORMATION

PRIMARY INSURANCE ______________ NAME OF POLICY HOLDER ______________

ID # ______________ GROUP # ______________ AMNT OF DEDUCTIBLE / COPAY: $ ______

SECONDARY INSURANCE ______________ NAME OF POLICY HOLDER ______________

ID # ______________ GROUP # ______________

PLEASE COMPLETE BOTH SIDES OF THIS FORM

POLICY HOLDER INFORMATION (FOR PRIMARY INSURANCE)

NAME ______________________________ DATE OF BIRTH ____ / ____ / ____
LAST FIRST MI

SS# [ ][ ][ ][ ][ ][ ][ ][ ][ ] OCCUPATION ______________________________

EMPLOYER ______________________________ (____) ______–________
WORK PHONE #

MY HEALTH INSURANCE COVERAGE IS THROUGH:

- [ ] SELF
- [ ] SPOUSE / DOMESTIC PARTNER
- [ ] OTHER
- [ ] EMPLOYER
- [ ] PARENT / GUARDIAN

____
SPECIFY

SPOUSE / DOMESTIC PARTNER INFO

NAME ______________________________ DATE OF BIRTH ____ / ____ / ____
LAST FIRST MI

EMERGENCY CONTACTS

1: ______________________________
LAST NAME FIRST

RELATIONSHIP TO PATIENT ______________________________ (____) ______–________
PHONE#

2: ______________________________
LAST NAME FIRST

RELATIONSHIP TO PATIENT ______________________________ (____) ______–________
PHONE#

INSURANCE AUTHORIZATION AND ASSIGNMENT

I HEREBY AUTHORIZE DRS. PAVLIDES, BENSON AND SHATS TO SUBMIT INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS.

I ASSIGN TO DRS. PAVLIDES, BENSON AND SHATS ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND AND AGREE THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

IF I DO NOT HAVE ANY INSURANCE OR THIS OFFICE DOES NOT PARTICIPATE WITH MY INSURANCE CARRIER, I UNDERSTAND AND AGREE THAT FULL PAYMENT IS DUE AT THE TIME OF MY VISIT.

I UNDERSTAND THAT IF I FAIL TO MAKE PAYMENT AT THE TIME OF MY VISIT OF MY CO-PAYMENT, BALANCE OR DEDUCTIBLE, I WILL BE CHARGED A BILLING FEE OF **$25.**

I UNDERSTAND AND AGREE THAT I WILL BE HELD RESPONSIBLE FOR THE ENTIRE BALANCE DUE AND SUBJECT TO DISMISSAL FROM THIS PRACTICE IF I AM NON-COMPLIANT WITH THE PAYMENT PRACTICES OF THIS OFFICE.

SIGNATURE ______________________________ DATE ____ / ____ / ____