NY HEALTH KIDNEY SPECIALISTS
Nephrology & Hypertension Specialists
2500 Nesconset Highway, Bldg. #14A
Stony Brook, NY 11790
Tel: (631) 689-7800
Fax: (631) 689-3016
nyhealth.com

PATIENT INFORMATION FORM

LAST NAME_____MI_____FIRST NAME_____

SOCIAL SECURITY #_____SEX_____DATE OF BIRTH_____

STREET ADDRESS_____

CITY_____STATE_____ZIP_____

HOME #_____WORK #_____CELL #_____

EMERGENCY CONTACT_____

RELATION TO PATIENT_____PHONE #_____

REFERRING MD_____PRIMARY MD_____

E-MAIL ADDRESS_____

Race _____American Indian/Alaskan Native _____Asian/Pacific Islander _____Caucasian
_____Black/African American _____Other _____Decline to Answer

Ethnicity _____Hispanic _____Non Hispanic ____Decline to Answer

PRIMARY LANGUAGE_____ (Note: Race, Ethnicity, primary language as above Required by CMS/Medicare)

EMPLOYMENT:

EMPLOYMENT STATUS (PLEASE CIRCLE) FULL-TIME RETIRED DISABLED UNEMPLOYED

EMPLOYER_____PHONE #_____

EMPLOYER ADDRESS_____

CITY_____STATE_____ZIP_____

INSURANCE:

PRIMARY INSURANCE_____POLICY ID # _____GROUP #_____ POLICY HOLDER NAME_____ RELATION TO PATIENT_____ POLICY HOLDER'S SS #_____POLICY HOLDER'S DOB_____

SECONDARY INSURANCE_____POLICY ID #_____GROUP #_____ POLICY HOLDER NAME_____RELATION TO PATIENT_____POLICY HOLDER'S SS #_____POLICY HOLDER'S DOB_____

I hereby authorize my provider to furnish information to insurance carriers concerning my illness and treatments and hereby assign to the physician all payment for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

GUARANTOR'S SIGNATURE_____DATE_____