MIDTOWN ALLERGY & ARTHRITIS CARE P.C.
PATIENT INFORMATION FORM

35 East 30th St, Ste 1A
New York, NY 10016
Tel: (212) 725-7027
Fax: (212) 725-0433

250 West 57th St, Ste 831
New York, NY 10019
Tel: (212) 957-8829
Fax: (212) 713-0438

[11:47:43 AM] Envelocity HR: THANK YOU FOR WRITING CLEARLY. PLEASE ATTACH YOUR MEDICAL INSURANCE CARD.

NAME: _____
LAST NAME FIRST NAME M.

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

DATE OF BIRTH: _____

SSN#: _____ MALE____FEMALE____

RACE: _____ETHNICITY_____HISPANIC_____NON-HISPANIC

TEL: #HOME_____CELL #_____

EMPLOYER NAME:_____WORK #_____

PCP or REFERRING DR'S NAME: _____TEL #_____
(If Dr. Ast is your PCP, enter his name above)

My Insurance Co: _____ID_____

Emergency Contact Name: _____Relation: _____

Address: _____City: _____State/Zip: _____

Tel: _____

PLEASE READ AND SIGN THE RELEASE AUTHORIZATIONS

ASSIGNMENT OF BENEFITS STATEMENT
I hereby request that payment of all authorized Insurance and Medicare benefits to be made to the above provider for services rendered to me by the provider.

RELEASE OF INFORMATION: I authorized and direct the above named physician, having treated me, to release all necessary records to process the claims to the Health Insurance Finance Adm., Insurance carriers or others who are financially liable for my medical care, or responsible to cover the costs of the care and treatment rendered to me.

Signed : _____Date: _____

The Provider will submit insurance covered claims at no cost to the patient. It is the patient's responsibility to make sure that their claims are paid. Patients are responsible for tracking their REFERRALS and PAYMENT for COPAY, DEDUCTIBLES AND UNINSURED CLAIMS.