72nd Street Medical Associates, P.C
310 East 72nd Street
New York, NY 10021

NAME: FIRST_____ M.I. _____ LAST _____

STREET_____

CITY_____ STATE_____ ZIP_____

HOME PHONE # _____

WORK PHONE # _____

MOBILE PHONE #_____

EMAIL _____

OCCUPATION: _____ COMPANY: _____

SSN: _____ DATE OF BIRTH:_____

REFERRED BY: _____ADDRESS _____

INSURANCE INFORMATION (OPTIONAL)

PRIMARY INSURANCE COMPANY & ADDRESS: _____

_____

NAME OF POLICY HOLDER: _____ RELATION: _____

POLICY ID # _____ GROUP # _____

I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELIEASE TO MY INSURANCE CARRIER OR ITS INTERMEDIARIES, OR TO THE OTHER BILLING AGENT OF THIS PHYSICIAN ANY MEDICAL INFORMATION NEEDED FOR THIS OR A RELATED INSURANCE CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL AND REQUEST PAYMENT OF MEDICAL BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT.

PATIENT SIGNATURE: _____

DATE: _____