PATIENT COMPUTER INFORMATION DATE:___________

PATIENT NAME_________________________ MARITAL STATUS M__S__D__W__

ADDRESS_________________________________ HOME NUMBER________________

CITY___________________ STATE____________ ZIP CODE__________________

SEX ______ BIRTHDATE__________________SOCIAL SECURITY#_______________

EMERGENCY CONTACT NAME________________ PHONE_____________________

PERSON RESPONSIBLE FOR BILL_____________________________________

ADDRESS IF DIFFERENT FROM ABOVE_________________________________

IF PATIENT IS FULL TIME COLLEGE STUDENT PLEASE COMPLETE:

SCHOOL_____________________________ DATE OF GRADUATION______________

INSURANCE INFORMATION:

PRIMARY INS CO	CERTIFICATE#	GROUP/PLAN	RELATIONSHIP Self sp ch ot
1.____________	____________	____________	__ __ __ __
SECONDARY INS.	CERTIFICATE#	GROUP/PLAN	RELATIONSHIP Self sp ch ot
2.____________	____________	____________	__ __ __ __

IF INSURANCE IS IN SOMEONE ELSE'S NAME PLEASE COMPLETE

NAME OF INSURED____

ADDRESS IF DIFFERENT____

TELEPHONE IF DIFFERENT_______________________INSURED DOB______________

EMPLOYMENT INFORMATION

MY EMPLOYER_____________________________ TELEPHONE#______________

ADDRESS_______________________________ OCCUPATION_________________

SPOUSE/PARENT EMPLOYER________________ TELEPHONE#__________________

ADDRESS_______________________________ OCCUPATION_________________

I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION NECESSARY TO PROCESS CLAIMS FOR MEDICAL BENEFITS. I AUTHORIZE PAYMENT OF BENEFITS TO LONG ISLAND FAMILY MEDICAL GROUP, P.C. FOR SERVICES PROVIDED.

SIGNATURE OF PATIENT_______________________________DATE_________________

1. Yellow Book
2. UC thru Insurance
3. Marie Serritella
4. Current Patient
5. Internet
6. Zip Pass
7. Friend
8. Employer