

PATIENT INFORMATION

EMPIRE MEDICAL SERVICES
64-10 Veterans Avenue
Brooklyn, NY 11234

Tel: 718-763-7071; Fax: 718-763-3045
Emsbrooklyn@empiredoc.com

Name: _____
(Last) (First) (Middle)

Sex: M F D.O.B: ____ - ____ - ____ SS#: ____ - ____ - ____
Marital Status: Single: Married: Separated: Other

Mailing Address: _____
Street City State Zip

Home Ph: _____ Cell Ph: _____ Work Ph: _____
E-MAIL: _____
Emergency Contact #: _____ Emergency Contact: _____
Race: _____ Ethnicity: _____

PRIMARY INSURANCE

INSURED NAME: _____
Last First

Relationship to Insured: _____

Sex: M F D.O.B: ____ - ____ - ____ SS#: ____ - ____ - ____

Policy #: _____ Group#: _____ INS. Ph. # _____

Mailing Address: _____
Street City State Zip

SECONDARY INSURANCE

INSURED NAME: _____
Last First

Relationship to Insured: _____

Sex: M F D.O.B: ____ - ____ - ____ SS#: ____ - ____ - ____

Policy #: _____ Group#: _____ INS. Ph. # _____

Mailing Address: _____
Street City State Zip

Authorization to released information and assignment of benefits to Physicians: I hereby authorized Empire Medical of Rockaway Beach P.C. Empire Medical Service and Heart Docs LLP to released information acquired in the course of my examination and my treatments. Also, I hereby assign payment of the medical benefits for the service rendered directly by Dr. V. Chakote and Associates. I understand that I am personally responsible for the charges cover by assignment. If I received payments from my insurance, I will return promptly to Empire Medical and Heart Docs LLP.

Patient Signature: _____ Date: _____