PATIENT INFORMATION

EMPIRE MEDICAL SERVICES
330 West 58th St., Suite. 301
New York, NY 10019

Tel: 212-769-4200; Fax: 212-871-1834
Emsmanhattan@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:** ______________