PATIENT INFORMATION

EMPIRE MEDICAL SERVICES
88-20 Rockaway Beach Blvd.
Rockaway Beach, NY 11693
Tel: 718—634-8080 Fax: 718-634-8087
Emsrockaway@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:** _____