1220 New Scotland Rd., Slingerlands, NY 12159 518-439-4326

Account #___________

Patient Name:____ Male:___ Female:___
Address:____ Social Security #:____________
City:____________________ State:______ Zip:__________ Date of Birth:_________ Age:______
Home Phone:______________ Cell Phone:_______________ Work Phone:______________
Email address:________________________________ Marital Status: S/M/D/W
Primary Care Physician:_____________________________ Phone #:__________________
Referring Physician:________________________________Phone #:__________________
Employer Name & Phone #:____
Employer Address:____
Emergency Contact:_________________________________Phone #:__________________
How did you hear about us?

- ❑ TV ad
- ❑ Newspaper
- ❑ Friend/Relative
- ❑ Website
- ❑ Physician
- ❑ Other

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PRIMARY INSURANCE:________________________________ Co-pay amount:__________
Address:____ Referral Needed: Y N
____ Member ID #:__________________
Policy Holders Name:___________________________ Social Security #:______________
Policy Holders Address:_________________________ Date of Birth: _______________
Insurance Group #:__________ Relation to Patient: Self____ Spouse____ Child____Other_______
Policy Holders Employer:_______________________________ If retired – Date:____________
Employers Address:___________________________________ Phone #:_________________

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SECONDARY INSURANCE:______________________________ Co-pay amount:__________
Address:____ Referral Needed: Y N
____ Member ID #:__________________
Policy Holders Name:___________________________ Social Security #:______________
Policy Holders Address:_________________________ Date of Birth: _______________
Insurance Group #:__________ Relation to Patient: Self____ Spouse____ Child____Other_______
Policy Holders Employer:_______________________________ If retired – Date:____________
Employers Address:___________________________________ Phone #:_________________

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WORKERS COMPENSATION INSURANCE CO.:__________________________________
Address:____ Phone #:_______________
____Date of Injury:______________
Employer at time of injury:____________________________ Carrier Case#:______________
Employer Address:__________________________________WCB#:____________________
Currently Working?: Yes___ No ___ If no, date stopped:__________Ins. Contact:______________

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NO FAULT INSURANCE:________________________________Phone #:_______________
Address____Date of Injury:_____________
____Claim #:__________________
Policy Holder Name:____________________________ _ Policy #:____________________
Currently Working?: Yes___ No ___ If no, date stopped:__________Ins. Contact:______________

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I authorize the release of any medical information necessary to process insurance claims, and the release of information back to my physician. I also authorize payment of medial benefits to the above state physician. Supplier, for services rendered.

SIGNATURE:____ Date: ______________