Craig M. Fern, M.D., P.C.

105 S. Bedford Rd. – Suite 311, Mt. Kisco, NY 10549
34 South Broadway – Suite 112, White Plains, NY 10601

PATIENT INFORMATION

PATIENT

Last Name:________________________________

First Name:________________________________

Phone #: H:_________________W:_____________
Cell:__________________

Address:___________________________ Apt:____

City:____________________ State:_____Zip:______

SS#:____________________________

Date of Birth:_______________Sex:________

SPOUSE/PARENT

Last Name:_____________________________

First Name:_____________________________

Phone #:________________________

SS#:________________________

Date of Birth:______________

Emergency Contact:_________________________ Phone Number:_______________

Who referred you to our office?_________________________________

Patient's Medical Doctor: ____________________________ Phone #:______________________

Doctor's Address: ___________________________________

Reason for visit:____

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PRIMARY INSURANCE INFORMATION

Is Primary coverage in the name of the patient _______spouse______parent__________

Insurance Co. Name:_________________________

Insurance Co. Address:_______________________

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Insurance ID#:______________________________

SECONDARY INSURANCE INFORMATION

Is secondary coverage in the name of the patient _____ spouse_______parent_________

Insurance Co. Name:_________________________

Insurance Co. Address:_______________________

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Insurance ID#:___________________

I hereby authorize the doctor indicated above or any other physicians he may designate to perform such examinations and treatments as are necessary to care for the medical condition of the patient named.

Signature:_____________________________________ Date:_________________________

(OVER)

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ASSIGNMENT OF BENEFITS:

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled including Medicare, HMO, private insurance and any other health plans to: **CRAIG M. FERN, M.D., P.C.** This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment. This information includes history obtained, physical findings, diagnosis and prognosis to my insurance company.

Signed:____Date:__________

HMO PATIENT AGREEMENT:

As a member of an HMO, I am aware of the responsibilities of my HMO contract. Specifically, it is my responsibility to secure a valid referral from my primary care physician for treatment by a specialist. I am also aware that without a valid referral, I am financially responsible for any evaluations, testing and/or treatments rendered by **CRAIG M. FERN, M.D., P.C.**

Signed:____Date:__________