

Westchester Retina

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

PATIENT INFORMATION

PATIENT

SPOUSE/PARENT

Last Name: _____

Last Name: _____

First Name: _____

First Name: _____

Phone #: H: _____ W: _____

Phone #: _____

Cell: _____

Date of Birth: _____

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

SS#: _____ Preferred Language _____ Race _____ Ethnicity _____

Date of Birth: _____ Sex: _____ Email Address _____

Pharmacy: _____ Phone: _____

Emergency Contact: _____ Phone Number: _____

Relationship to Patient: _____

Referring Physician: _____

Primary Care Physician: _____ Phone #: _____

Address: _____

Reason for visit: _____

PRIMARY INSURANCE INFORMATION

Is Primary coverage in the name of the
Patient: _____ Spouse: _____ Parent: _____

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance ID#: _____

SECONDARY INSURANCE INFORMATION

Is secondary coverage in the name of the
Patient: _____ Spouse: _____ Parent: _____

Insurance Co. Name: _____

Insurance Co. Address: _____

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: _____

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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:** _____