JEFFREY A. SKLAR, M.D. F.A.AD.
DOUGLAS J. MELMAN, M.D. F.A.A.D
TODD R. COVEN, M.D. F.A.A.D.
ELIZABETH FEMENIA, R.P.A.-C.
TARA KOCH, R.P.A.-C.

PATIENT INFORMATION FORM

PATIENT

Last Name ______________________ First Name ______________________ MI___

Date Of Birth ______________________ Home Phone ( ) ______________________

Address ______________________ Work Phone ( ) ______________________

City, State, Zip______________________ Cell Phone ( ) ______________________

Gender: ☐ Male ☐ Female Social Security Number __________ /_______ /________

Marital Status: ☐Sgl ☐Mar ☐Div ☐Wid ☐Sep

Primary Care Doctor (REQUIRED) ______________________ Pharmacy Name ______________________

Referred By ______________________ Pharmacy Phone ( ) ______________________

How Did You Hear About Us? ______________________ Patient's Employer ______________________

Email Address ______________________ Occupation ______________________

In Case of Emergency, Who May We Contact? ______________________ Phone ( ) ______________________

POLICY HOLDERS INFORMATION

Primary Insurance Company Name ______________________ ID# ______________________ Group# ______________

Last Name ______________________ First Name ______________________ MI___

Date Of Birth ______________________ Home Phone ( ) ______________________

Address ______________________ Work Phone ( ) ______________________

City, State, Zip______________________ Cell Phone ( ) ______________________

Relationship to Insured ______________________

Secondary Insurance Company Name ______________________ ID# ______________________ Group# ______________

Last Name ______________________ First Name ______________________ MI___

Date Of Birth ______________________ Home Phone ( ) ______________________

Address ______________________ Work Phone ( ) ______________________

City, State, Zip______________________ Cell Phone ( ) ______________________

Relationship to Insured ______________________

I certify that this information is true and correct "to the best of my knowledge". I will notify you of any change in the above information. I authorize the release of any medical information necessary to process an insurance claim and request that benefits be made to the physician unless my account has been paid in full. I agree that I have financial responsibility for payment of service rendered. For any participating plan, my responsible charges will be determined by the insurance company.

Signature of Patient or Parent if Under 18 yrs old ______________________ Date ______________________

800 Woodbury Road, Woodbury, New York 11797 Phone (516) 496-9400 Fax (516) 496-9212