

SISSELMAN MEDICAL GROUP, PC

100 Veterans Boulevard, Suite 2
Massapequa, NY 11758

Telephone: (516) 308-4040
Fax : (516) 804-6386

Referred by: _____

Patient Name: _____

SS#: _____ DOB: _____ Age: _____

Address: _____ Sex: _____ Marital Status: _____
(street)

_____ E:mail: _____
(town, state, zip)

Phone #: _____ Alternate #: _____

Employer: _____

Nearest Friend or Relative: _____

Primary Insurance: _____
(name, ID#, group#, address, phone #)

Primary Insured: _____
(name, SS#, date of birth)

Secondary Insurance: _____
(name, ID#, group#, address, phone #)

Secondary Insured: _____
(name, SS#, date of birth)

Allergies to Medication: _____

Reason for Visit: _____

Signature on File: By signing below, I: 1. authorize use of this form on all on my insurance submissions. 2. authorize release of information to all of my insurance companies. 3. authorize my health care provider to act as my agent in helping me obtain payment from my insurance company. 4. authorize payment directly to my healthcare provider(s) — Sisselman Medical Group, P.C., ..5. permit a copy of this authorization to be used in place of the original. 6. understand that I am responsible for my bill. 7. understand that if my health care providers accept assignment, I am responsible for any amount not paid by my insurance company.

Patient Name: (print) _____ Date: _____

Patient/Guardian Signature: _____