

PATIENT INFORMATION

NAME (Last, First, Middle)	SS#	BIRTHDATE	SEX
LOCAL ADDRESS	PRIMARY EMPLOYER		
CITY, STATE, ZIP	ADDRESS		
HOME PHONE	CITY, STATE, ZIP		
WHO IS YOUR PRIMARY CARE PHYSICIAN?	WORK PHONE		
E-MAIL ADDRESS:			

RESPONSIBLE PARTY INFORMATION (if different from above)

NAME (Last, First, Middle)	SS# REQUIRED	DOB REQUIRED	SEX
LOCAL ADDRESS	SECONDARY/BILLING ADDRESS (If Applicable)		
CITY, STATE, ZIP	CITY, STATE, ZIP		
HOME PHONE	HOME PHONE		
RELATIONSHIP TO PATIENT			

INSURANCE INFORMATION

NAME OF PRIMARY INSURANCE	POLICY #
NAME OF INSURED/RELATIONSHIP TO PATIENT	COPAY AMOUNT
SECONDARY INSURANCE	POLICY #
NAME OF INSURED/RELATIONSHIP TO PATIENT	COPAY AMOUNT

HOW DID YOU HEAR ABOUT OUR OFFICE? [] FAMILY/FRIEND _____ [] PATIENT _____
 [] NEWSDAY [] LI WOMAN [] WOODBURY MAGAZINE [] OUR WEBSITE [] INTERNET [] OTHER _____
 IF REFERRED BY ANOTHER DOCTOR, PLEASE GIVE NAME, ADDRESS AND PHONE _____

WHO SHALL WE CALL IN CASE OF EMERGENCY? PLEASE GIVE NAME, RELATIONSHIP TO YOU AND PHONE #

IS ANYONE AUTHORIZED TO MAKE INQUIRIES TO OUR OFFICE ON YOUR BEHALF? IF SO, PLEASE PROVIDE THEIR NAME AND THEIR RELATIONSHIP TO YOU

NAME: _____ RELATIONSHIP: _____

 SIGNATURE OF PATIENT / GUARDIAN

 DATE

Name: _____

Please list **ALL** medications you are currently taking (including herbal supplements/diet pills/OTC's/etc.):

Allergic to any medications? **YES NO** If yes, please list:

Do you have the following?	Yes (√)	No (√)	If yes, please describe here:
Neurological disease or disorder			
Headaches			
Heart Disease			
High Blood Pressure			
Circulatory Problems			
Asthma or Bronchitis			
Diabetes			
Thyroid disease or other endocrine disorders			
Skin Diseases			
Gastro-intestinal Disorders			
Liver Disease			
Kidney Problems			
Arthritis or other joint/muscle diseases			
Bleeding Disorders			
Blood Clots			
Immune Disorders			
Psychiatric Problems			
Cancer or Tumors			
Prostate Problems (men)			
Obstetric or Gynecologic Problems (women)			
Sexually Transmitted Diseases			
Are you pregnant?			
Have you had surgery? (please list)			
Other problems listed above?			
Are immunizations up to date?			

 SIGNATURE OF PATIENT / GUARDIAN

 DATE

PATIENT NAME (PLEASE PRINT)



FINANCIAL POLICY

Thank you for selecting our office for your medical care. In an effort to prevent any misunderstandings concerning the responsibility for payment for services rendered, it is necessary for you to read and fully understand the following information prior to your visit with the Doctor.

The patient or guarantor is responsible for payment at the time services are rendered. The only exception our office will make to this rule occurs when the Doctor is a participating provider of your HMO/PPO. In these cases, we will accept the insurance as payment in full ONLY AFTER all deductibles and copays have been paid. If you choose to be billed, we will charge a fee of \$10 in addition to the amount of your copay. Upon request, we will gladly furnish you with a copy of your bill for presentment to your insurance company.

PATIENT RESPONSIBILITIES

All referrals must be obtained prior to your visit with the specialist Doctor(s) in our office. Please ensure you have determined the necessity for referrals before arriving for your appointment. These are required by your insurance carrier and as such, it is important for you as the patient to be aware of when they are needed, the number of visit(s) allowed and their expiration dates. **IT IS NOT THE RESPONSIBILITY OF OUR STAFF TO OBTAIN REFERRALS FOR YOU.**

MEDICARE

Dr. Schlessinger is a participating Medicare provider. All Medicare patients incur an annual deductible each calendar year in addition to the 20% of the approved Medicare fee that is not covered by Medicare. As a courtesy, we will bill you for any Medicare balances after Medicare pays their portion of your bill.

SERVICES NOT COVERED BY INSURANCE PLANS

Some services including refractions (glasses prescriptions), supplies and cosmetic services are not covered by your insurance plan. If you request or require a non-covered service, payment will be expected at the time services are rendered. Some insurance companies require an additional copay (double-copay) for diagnostic testing. We will collect this at the time services are rendered. Cosmetic appointments require a 20% deposit. This fee is non-refundable. If you do not show-up for your appointment or fail to cancel within 24-hours the deposit will act as a no-show fee. **PAYMENT FOR ALL COSMETIC/AESTHETIC PROCEDURES AND PRODUCTS IS EXPECTED AT THE TIME OF YOUR VISIT.**

BOUNCED CHECK POLICY

We will impose a \$25-fee for any check that is returned by the bank as unpaid for any reason.

APPOINTMENT POLICY

If you expect to arrive late for your appointment, please call to let us know. We may ask you to re-schedule if you arrive more than 15-minutes late. Please notify the office at least 24-hours in advance if you must reschedule your appointment. We regret that you will be billed a \$25.00-cancellation fee for any appointment not rescheduled at least 24-hours prior to the appointment time.

I HAVE READ THE ABOVE AND FULLY UNDERSTAND BOTH THE FINANCIAL AND THE APPOINTMENT POLICIES AS STATED. I FURTHER ECOGNIZE THAT MY SIGNATURE ON THIS FORM SIGNIFIES MY CONSENT TO ANY FUTURE VERSIONS AND/OR UPDATES.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

TODAY'S DATE