Patient Information Form ❑ **NEW** ❑**UPDATE** **Sidney J. Goldfarb, MD**

(Please print clearly)

Demographic Information

LAST Name:	FIRST Name:	M.I.	Previous Name:
Mailing (Street) Address:			Apt. #
City/State/Zip:			
Home Phone:	Cell Phone:	Work Phone:	
Email:	**Preferred** Method of Contact: ❑ Home ❑ Cell ❑ Work ❑ Email	May we leave a message regarding your medical care & test results? ❑ Yes ❑ No	
Date of Birth:	Age:	Sex: ❑ Male ❑ Female	
Marital Status:	Social Security #:	Employer Name:	
Race: ❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American ❑ Native Hawaiian or Pacific Islander ❑ White ❑ Prefer not to answer		**Ethnicity:** ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Prefer not to answer	
		Preferred Language:	

Physician & Pharmacy

Referring Physician:	Phone Number:
Primary Physician:	Phone Number:
Preferred Pharmacy Name:	Pharmacy Phone Number:
Pharmacy Address:	
Mail Order:	Phone Number:
Prescription Plan:	Plan #:

Emergency

Emergency Contact LAST Name:	Emergency Contact FIRST Name	Emergency Contact MIDDLE Initial:
Emergency Contact Address:		
Emergency Contact CELL Phone #:	Emergency Contact HOME Phone #:	Emergency Contact WORK Phone #:
Emergency Contact EMAIL:		Relationship to Patient:

Insurance Information & Responsible Party

Person responsible for the bill (ONLY IF DIFFERENT THAN THE PATIENT):		
Last Name:	First Name:	
Date of Birth:	SSN:	Phone:
Address (if different from patient):		
City/State/Zip:	Relationship to Patient:	

PRIMARY Medical Insurance	**SECONDARY Medical Insurance**
Ins. Co. Name:	Ins. Co. Name:
Policy ID #:	Policy ID #:
Group #:	Group #:
Policy Holder Name:	Policy Holder Name:
Policy Holder DOB:	Policy Holder DOB:
Policy Holder Address:	Policy Holder Address:
Relationship to Policy Holder: ❑ Self ❑ Spouse ❑ Child ❑ Other:	Relationship to Policy Holder: ❑ Self ❑ Spouse ❑ Child ❑ Other:

I hereby authorize MEDICARE and/or other INSURANCE benefits for services furnished to be paid directly to SIDNEY J. GOLDFARB, M.D. I also agree to fully accept financial responsibility for all non-covered services and will pay outstanding balances upon receipt of the monthly statement.

I understand that if my health insurance policy requires a referral in order to cover services, it is my responsibility to obtain a referral from my insurance company for each applicable date of service and/or procedure.

I authorize SIDNEY J. GOLDFARB, M.D. to release to Medicare Services, my Insurance Carrier and/or its agents, any information required in the processing of all submitted claims.

I have received and reviewed SIDNEY J. GOLDFARB, M.D.'s Patient Acknowledgment of and Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Health Care Operations; Disclosure of Financial Interests; and Notice of Privacy Practices and hereby give my acknowledgment and consent.

Signature of Responsible Party:
(Patient or Legal Guardian) _____ Date: _____

Printed Name of Responsible Party: _____