LONG ISLAND MEDICAL CARE SERVICES, P.C.
PATIENT INFORMATION SHEET

PATIENT INFORMATION

ACCOUNT #______________

Sex: **M** **F** Date of Birth: _____/_____/_____

Patient Name:_____________________________________

Address:____

City, State, Zip____________________________________

Home Phone:_________________ Cell Phone:________________

E-mail address:_____________________________________

*** IT IS EXTREMELY IMPORTANT THAT YOU GIVE US YOUR E-MAIL ADDRESS & CELL # FOR OUR DATA BASE TO ENSURE MORE EFFICENT COMMUNICATION EFFORTS. PLEASE BECOME A PART OF OUR PORTAL COMMUNITY BY VISITING OUR WEBSITE: WWW.LIMCPC.COM AND SIGNING UP TODAY!**

Social Security # _________ - _________ - _________

Employer:____

Address:____

City, State, Zip___________________________________

Phone:__________________________ Ext.____________

Emergency contact:_______________________________

Emergency Contact Phone_________________________

Relationship to Patient:___________________________

GUARANTOR INFORMATION *(Person who insurance is under. Card Holder.)*

GUARANTOR INFORMATION SAME AS ABOVE? YES NO

Guarantor Name:__________________________________

Address:____

City, State:_______________________________________

Zip:________________ Home Phone:________________

Guarantor Soc. Sec. #________ - _______ - ________

Date of Birth: ______/______/______ Sex: **M** **F**

Relationship to Patient:___________________________

Guarantor Employer:_____________________________

Address:____

City, State, Zip:__________________________________

INSURANCE INFORMATION *(Pertains to policy holder)*

PRIMARY

Insurance Company:____

Policy ID#:___________________________________ Group#_____________________________________

Phone Number (Provider # off back of insurance card):____

SECONDARY

Insurance Company:____

Policy ID#:___________________________________ Group#_____________________________________

Phone Number (Provider # off back of insurance card):____

CONTINUED ON BACK

PATIENT INFORMATION SHEET

PHARMACY INFORMATION

Local Pharmacy:_________________________________

Town:____

Phone #:____

Mail Away Pharmacy:_____________________________

IN ORDER TO BE COMPLIANT WITH NEW GOVERNMENT REGULATIONS FOR MEANINGFUL USE WITH ELECTRONIC MEDICAL RECORDS WE REQUIRE THE FOLLOWING:

RACE: AMERICAN INDIAN____ ASIAN____ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER____ BLACK OR AFRICAN AMERICAN____ WHITE____ HISPANIC____ OTHER RACE____ OTHER PACIFIC ISLANDER____ REFUSE TO REPORT____

ETHNICITY: HISPANIC OR LATIN___ _NOT HISPANIC OR LATIN____ REFUSE TO REPORT____

LANGUAGE: ENGLISH____ OTHER____ INDIAN (INCLUDES HINDI & TAMIL)____ SPANISH____ RUSSIAN____

Please initial below:

I certify that I am aware of and understand LIMC office policies. _______________

I was told about the office website (www.limcpc.com), the Patient Portal, providing your email address, and our Credit Card Authorization/Prepayment form. ____________________

ASSIGNMENT OF BENEFITS: I ASSIGN ALL MEDICAL AND/OR SURGICAL BENEFITS TO WHICH I AM ENTITLED INCLUDING MAJOR MEDICAL, MEDICARE, PRIVATE INSURANCE AND ANY OTHER HEALTH PLANS TO LONG ISLAND MEDICAL CARE SERVICES. THIS AGREEMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. A PHOTOCOPY OF THIS ASSIGNMENT IS TO BE CONSIDERED AS VALID AS THE ORIGINAL. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES NOT PAID BY INSURANCE. I HEREBY AUTHORIZE SAID ASSIGNEE TO RELEASE ALL INFORMATION NECESSARY TO SECURE PAYMENT.

Signature:_________________________________**Date:**________________________

PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED