Northwell Health Physician Partners | Westchester Health

PATIENT INFORMATION

Last Name_____First Name_____Initial _____

Date of Birth_____Sex _____

Address _____ City_____State_____Zip_____

Race_____Language_____Marital Status _____

Ethnicity (please select one) Hispanic_____non-Hispanic_____declined_____

Primary Care Physician _____

Referring Physician _____

Home Phone # _____ Cell Phone #_____Work Phone # _____

Please indicate which number is your Preferred Method of Contact _____

E-Mail Address _____

Preferred Pharmacy Name_____Phone _____

Employer Name_____Address _____

In Case Of Emergency Who Should We Notify _____

Phone Number_____Relationship _____

If patient is under 18, please indicate Legal Guardian _____

If patient is under 18, please indicate Mother's Maiden Name _____

INSURANCE INFORMATION - Primary Insurance

Plan Name_____Policy #_____Group # _____

Name of Insured (Policy Holder) _____

Relationship to Patient_____Date of Birth_____

Address_____City_____State _____

Home Phone #_____Work Phone # _____

Secondary Insurance (if Applicable)

Plan Name_____Policy #_____Group # _____

Name of Insured (Policy Holder) _____

Relationship to Patient_____Date of Birth_____

Address_____City_____State _____

Home Phone #_____Work Phone # _____

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Westchester Health Medical will not contact you regarding your confidential medical information via email. We are in the process of developing a secure patient portal for direct internet access. We do not sell or distribute email addresses. We will use email addresses to inform you about upcoming seminars or important health recommendations. If you do not wish to receive emails from Westchester Health Medical, please write none.

Please identify if have any barriers to communication, for example, need interpreter, having hearing or vision barriers

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I, the undersigned, hereby certify that I have Insurance coverage and assign all insurance benefits to Westchester Health Medical, if any, for services rendered. I understand that I am responsible for all co-payments/co-insurance, deductibles and otherwise elective non-covered services provided to me (or my dependents). I authorize the use of this signature on all insurance submissions.

I, the undersigned, hereby agree that I am financially responsible for all services provided to me by Westchester Health Medical.

Signature_____Date _____

Westchester Health Medical is an equal opportunity employer and healthcare organization. We are committed to excellent health care for all of our patients. Questions related to patients' race and ethnicity are included to comply with federally mandated programs for utilizing an electronic health record. You may decline to answer these questions.