

# PATIENT INFORMATION SHEET

Today's Date:

Please print information clearly on both sides of this form. Thank you.

Patient's Name			SS#	Date of Birth												
Last			First	Middle												
Address																
No.		Street		Apt. No.	City	State		Zip								
Relationship to Guarantor			Sex		F	M	Marital Status		(S)	(M)	(Co)	(Sep)	(W)	(D)	Work Status	
Home Telephone		Work Telephone			Cell Phone			Fax #								
e-mail address				Referring Physician's Name & Address												
Employer's Name/Address																
Name		Street		City	State	Zip										
Employer's Telephone No.		Contact Person's Name & Relationship			Contact Phone #											
Contact Address				Contact Work #			Contact Cell #									

## INSURED'S INFORMATION

The following section is not necessary to complete if the insured is the patient.

Insured's Name				Date of Birth		Social Sec. No.			
Last		First		Middle		Must complete		Must complete	
Insured's Employer:				Employer's Telephone					
Employer's Address:									
No.		Street		Apt. No.	City	State	Zip		
Relationship to Patient		<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Employer	<input type="checkbox"/> Other	Insured's e-mail Address			

The following section does not need to be completed if it is the same as the patient's information.

Home Address - If different from patient								
No.		Street		Apt. No.	City	State	Zip	
Home Telephone		Emergency Telephone						

## INSURANCE INFORMATION

If you have given us a copy of your insurance card, you do not need to complete the insurance information in this section

Primary Insurance Carrier:				Subscriber's Name				
Carrier's Address								
No.		Street		Apt. No.	City	State	Zip	
Carrier's Telephone No.		Plan No.			Group No.			
Secondary Insurance Carrier				Subscriber's Name				
Secondary's Address								
No.		Street		Apt. No.	City	State	Zip	
Secondary's Telephone No.		Plan No.			Group No.			

## ACCIDENT CASES

Type of Accident		<input type="checkbox"/> Workers Comp	<input type="checkbox"/> No-Fault	<input type="checkbox"/> Liability	Date of Accident		
Insurance Carrier:					Name of Adjuster:		
Address							
No.		Street		City	State	Zip	
Telephone No.		Attorney's name			Attorney's Telephone No.		
Claim No.		Carrier Case No.			WCB #		

\* PLEASE COMPLETE  
BACK SIDE OF THIS  
FORM

**ALL PATIENTS PLEASE COMPLETE SECTION I**

**SECTION I**

**Insurance Payment Order Form & Release of Information and Medical Records**

I hereby authorize my Insurance carrier/Medicare carrier to pay benefits directly to Healthcare Associates in Medicine, P.C. under the terms of my policy. Furthermore, I hereby authorize you to release to my Insurance carrier/Medicare carrier my medical records pertaining to my medical care and treatment. I fully understand that no further authorization is necessary to release this information other than this document.

Patient's Name \_\_\_\_\_ Patient or Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

**NO-FAULT PATIENTS PLEASE COMPLETE SECTION I AND SECTION II**

**SECTION II**

**NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW  
ASSIGNMENT OF BENEFITS FORM**

I, \_\_\_\_\_ ("Assignor") hereby assign to Healthcare Associates in Medicine ("Assignee") all rights privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on \_\_\_\_\_, notwithstanding any prior written agreement to the contrary. This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

Patient's Name \_\_\_\_\_ Patient or Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

Provider's Name \_\_\_\_\_ Provider's Signature \_\_\_\_\_ Date \_\_\_\_\_

**WORKERS' COMPENSATION PATIENTS PLEASE COMPLETE SECTION I & SECTION III**

**SECTION III**

**State of New York**

**WORKERS' COMPENSATION BOARD**

**CLAIMANT'S AUTHORIZATION TO DISCLOSE WORKERS' COMPENSATION RECORDS**

Pursuant to Workers' Compensation Law Section 110-a

Claimant's Name \_\_\_\_\_ Claimant's Social Security Number \_\_\_\_\_

Claimant's WCB No. \_\_\_\_\_ Date of Accident \_\_\_\_\_    Records Authorized for Release:  
Future Notices of Hearing/Notices of Decision (attending doctor only)  
Entire file(s)  
Specific Document(s) - give details below

Reason for Disclosure of \_\_\_\_\_

**INSTRUCTIONS:**

Submit original to the Workers' Compensation Board and retain a copy for your records. Authorization for disclosure of records for certain purposes is not valid under the law. See excerpt of WCL Section 110-a.

Pursuant to Section 110-a of the Workers' Compensation Law, I \_\_\_\_\_ represent that I am a person who is/was the subject of the Workers' Compensation case(s) indicated above, and I authorize the Workers' Compensation Board to discuss the above-referenced records to Healthcare Associates in Medicine, P.C. at 1099 Targee Street, Staten Island, NY 10304. I understand that the requesting party may be required to pay a statutory fee prior to being provided copies of these records by the Workers' Compensation Board.

Claimant's Name \_\_\_\_\_ Claimant's Signature \_\_\_\_\_ Date Signed \_\_\_\_\_