STEVEN G. WALLACH, M.D.

14 EAST 90TH STREET SUITE 1B
PHONE (212)861-6400 FAX 917-636-5827

Patient's Name: _____ Sex: _____

Social Security #: _____ Date of Birth: _____ Age: _____ Marital Status: _____

Address: _____
(Street) (Apt) (City) (State) (Zip)
Home Phone: _____ Email: _____ Business Phone: _____

Would you like to receive our monthly newsletters with news and specials? □ Yes □ No

Personal Physician Name and Address:_____

Employer: _____ Occupation: _____

Employer's Address: _____
(Street) (City) (State) (Zip)

Person Responsible for Bill: _____ Phone: _____ Relationship: _____

Address: _____
(Street) (Apt) (City) (State) (Zip)
Referred By: _____ Address: _____ Phone: _____

Person to be notified in case of emergency, Name: _____ Relationship:_____

Address: _____ Home Phone: _____ Business Phone: _____

Reason for today's visit:_____

If Married,
Spouse: _____ Social Security #: _____ Date of Birth: _____

Employer: _____ Occupation:_____

Employer's Address:_____
(Street) (City) (State) (Zip)

Insurance Information
Insurance Carrier Name & Address: _____

Name of Insured:_____ Relationship: _____ SS#: _____

Identification #: _____ Policy #:_____ Group#: _____

Secondary Insurance Carrier Name & Address: _____

Name of Insured:_____ Relationship: _____ SS#:_____

Identification #: _____ Policy #:_____ Group#: _____

I hereby authorize Steven G. Wallach, M.D. to furnish my insurance company and/or Physician all information which the insurance company may request concerning my present illness or injury. I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare and any other health plans to Steven G. Wallach, M.D. This assignment 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 to Steven G. Wallach, M.D. for all charges whether or not paid by said insurance. In addition, I have received or reviewed the "Notice of Privacy Practices for Protected Health Information" as required by the Health Insurance Portability & Accountability Act of 1996 and it is also available for review and is posted in the office.

_____
Signature of Patient/Responsible Party Date Signed