HOWARD ANTHONY ROSE, M.D., P.C. 535 East 70th Street, New York, NY 10021 212-606-1278

FOR OFFICE USE ONLY

MEDICAL RECORD#

PATIENT'S LAST NAME:	FIRST:	MI:	DATE OF BIRTH (MM/DD/YY)	BIRTH PLACE
			/ /	

ADDRESS (no., street, apt#)	CITY	STATE	ZIP

HOME PHONE	CELL PHONE	SEX	E-MAIL ADDRESS
- -	- -	❑ F ❑ M	

RACE	RELIGION	MARITAL STATUS	SOC. SEC. NUMBER
		❑ S ❑ M ❑ D ❑ W	- -

PATIENT'S EMPLOYMENT (If full-time student provide information on school)

NAME OF EMPLOYER/ SCHOOL	PATIENT OCCUPATION	❑Full-Time ❑ Part-Time ❑Retired ❑ Student
EMPLOYER/ SCHOOL ADDRESS (no., street, city, state, zip code)		WORK/ SCHOOL PHONE - -

GUARANTOR (Primary Insurance Policy Holder)

❑ Self ❑ Spouse ❑ Parent/Guardian ❑ Other (If guarantor other than self, provide person's information below)

GUARANTOR'S FULL NAME (LAST, FIRST, MI)	DATE OF BIRTH (MM/DD/YY) / /	SEX ❑ F ❑ M
ADDRESS (no., street, apt#)	CITY	ZIP

HOME PHONE	WORK PHONE	SOC. SEC. NUMBER
- -	- -	- -

NAME OF EMPLOYER	OCCUPATION	❑ Full-Time ❑ Part-Time ❑ Retired ❑ Student
EMPLOYER ADDRESS (no., street, city, state, zip code)		

RELATIVES (Persons to be notified in case of emergency)

RELATIVE #1 FULL NAME	RELATIONSHIP	PHONE NUMBER - -
RELATIVE #2 FULL NAME	RELATIONSHIP	PHONE NUMBER - -

MEDICAL DETAIL

CHIEF COMPLAINT / REASON FOR APPOINTMENT:	ALLERGIES:

IS THIS AN ACCIDENT? ❑ YES ❑ NO	ACCIDENT TYPE: ❑ EMPLOYMENT ❑ VEHICLE ❑ OTHER	ACCIDENT DATE/TIME: : ❑ AM ❑ PM / /
HAVE YOU BEEN HOSPITALIZED IN THE LAST 3 MONTHS? ❑ YES ❑ NO	WHEN? / /	WHERE?

PHYSICIAN / REFERRAL

PATIENT PRIMARY CARE PHYSICIAN:	PHONE NUMBER: - -
REFERRING PERSON/PHYSICIAN:	

PRIMARY INSURANCE: ❑ MEDICARE ❑ OXFORD/ UNITED HEALTHCARE ❑ CIGNA ❑ AETNA ❑ WORKMAN'S COMP ❑ NO-FAULT ❑ OTHER

INSURANCE COMPANY NAME:			ID/POLICY NUMBER:
INSURANCE COMPANY ADDRESS:			PHONE NUMBER:
MAIN POLICY HOLDER:	RELATIONSHIP:	GROUP/CLAIM NUMBER:	PLAN NUMBER:

SECONDARY INSURANCE ❑ MEDICARE ❑ OXFORD/ UNITED HEALTHCARE ❑ CIGNA ❑ AETNA ❑ WORKMAN'S COMP ❑ NO-FAULT ❑ OTHER

INSURANCE COMPANY NAME:			ID/POLICY NUMBER:
INSURANCE COMPANY ADDRESS:			PHONE NUMBER:
MAIN POLICY HOLDER:	RELATIONSHIP:	GROUP/CLAIM NUMBER:	PLAN NUMBER:

ASSIGNMENT AND RELEASE OF INFORMATION STATEMENT - I certify that the information given by me is correct. I understand that this information is entered into a database, and I hereby authorize the sharing of such information with Hospital affiliated physicians who are responsible for my care and their offices. I hereby also authorize the release of information related to my medical care, as requested by government agencies and/or insurance carriers. I hereby assign benefits to Howard A. Rose, MD and understand that in the absence of accepted insurance coverage, I/legal guardian am responsible for full payment of services rendered and attorney/collection fees that may accrue.

MEDICARE PATIENTS - I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I understand that I am responsible for insurance deductibles on all services, 20% co-insurance on ancillary services. When Medicare is deemed the secondary insurance, I will follow payment terms under Dr. Howard A. Rose's office policies.

EFFECTIVE DATE - These statements shall be efective from the date of the signature below until December 31 of the current year, unless you notify this office otherwise in writing at the address written above, or there is a change in any of the above statements.

PATIENT OR GUARDIAN SIGNATURE: _____ **DATE:** _____

Print Form