

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 <input type="checkbox"/> F <input type="checkbox"/> M	E-MAIL ADDRESS
RACE	RELIGION	MARITAL STATUS <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W		SOC. SEC. NUMBER	
PATIENT'S EMPLOYMENT (If full-time student provide information on school)					
NAME OF EMPLOYER/ SCHOOL			PATIENT OCCUPATION		<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Retired <input type="checkbox"/> Student
EMPLOYER/ SCHOOL ADDRESS (no., street, city, state, zip code)				WORK/ SCHOOL PHONE	
GUARANTOR (Primary Insurance Policy Holder)					
<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> 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 <input type="checkbox"/> F <input type="checkbox"/> M	
ADDRESS (no., street, apt#)				CITY	
				ZIP	
HOME PHONE		WORK PHONE		SOC. SEC. NUMBER	
NAME OF EMPLOYER			OCCUPATION		<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Retired <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO		ACCIDENT TYPE: <input type="checkbox"/> EMPLOYMENT <input type="checkbox"/> VEHICLE <input type="checkbox"/> OTHER		ACCIDENT DATE/TIME: ____ : ____ <input type="checkbox"/> AM <input type="checkbox"/> PM ____ / ____ / ____	
HAVE YOU BEEN HOSPITALIZED IN THE LAST 3 MONTHS? <input type="checkbox"/> YES <input type="checkbox"/> NO			WHEN? ____ / ____ / ____		WHERE?
PHYSICIAN / REFERRAL					
PATIENT PRIMARY CARE PHYSICIAN:			PHONE NUMBER:		
REFERRING PERSON/PHYSICIAN:					
PRIMARY INSURANCE: <input type="checkbox"/> MEDICARE <input type="checkbox"/> OXFORD/ UNITED HEALTHCARE <input type="checkbox"/> CIGNA <input type="checkbox"/> AETNA <input type="checkbox"/> WORKMAN'S COMP <input type="checkbox"/> NO-FAULT <input type="checkbox"/> OTHER					
INSURANCE COMPANY NAME:				ID/POLICY NUMBER:	
INSURANCE COMPANY ADDRESS:				PHONE NUMBER:	
MAIN POLICY HOLDER:		RELATIONSHIP:		GROUP/CLAIM NUMBER:	
PLAN NUMBER:					
SECONDARY INSURANCE <input type="checkbox"/> MEDICARE <input type="checkbox"/> OXFORD/ UNITED HEALTHCARE <input type="checkbox"/> CIGNA <input type="checkbox"/> AETNA <input type="checkbox"/> WORKMAN'S COMP <input type="checkbox"/> NO-FAULT <input type="checkbox"/> 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 effective 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: _____	