NORTH SHORE INFECTIOUS DISEASE CONSULTANTS, PC

44 South Bayles Avenue
Port Washington, New York 11050-3765
Tel# 516-767-7771 Fax # 516-767-7765

Date: ____________

Patient Information

Last Name: ________________________ First Name: __________________ M.I: _______
Address: ____
City: ___________________________________ State: ________ Zip Code: __________________
Home #:______________________ Cell# ____________________ Work#____________________
Birth Date: ______________ Age: _____ Social Security #: ________________ Sex: F / M
Married __ Single __ Widowed __ Divorced __ Separated __
Email: ______________________________________ Employer: ____________________________

Please check off ALL that apply
ETHNICITY: ___ Hispanic or Latino ___ Not Hispanic or Latino
RACE: ___ African American ___Asian ___White/Caucasian ___American Indian ___Other:

Pharmacy Information

Name: _______________________________ Phone#: ___________________________________
Address: ____
City: _______________________________ State: _________ Zip Code: _____________________

Physician Information

Referring Doctor: ______________________________________ Phone #:___________________
Address: ____
City: _______________________________ State: ________ Zip Code: ______________________

Primary Care Doctor: __________________________________ Phone#: ___________________
Address: ____
City: _______________________________ State: ________ Zip Code: ______________________

Insurance Information

Primary Ins.: ___________________________ ID#: ________________ Group #:_____________
Subscriber: _______________________ Relationship: _____________ D.O.B: _______________

Secondary Ins.: ______________________ ID#: _________________ Group#: _______________
Subscriber: ______________________ Relationship: _____________ D.O.B. _________________

IS THIS VISIT ACCIDENT RELATED? Yes: _____ No: _____
DATE OF ACCIDENT: ___/___/____

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David Brieff, M.D.
Alan M. Bulbin, M.D.
Dava L. Klirsfeld, M.D.
Vitaliy Krol, D.O
Farah Shams, M.D
Nathalie Schulhof, M.D.
Hermes Lopez, M.D.

Patient's Name: ____

I have received a copy of the Notice of Privacy Practices of North Shore Infectious Diseases Consultants, PC

I, hereby give you permission to speak to the people I have listed below, regarding any of my medical issues:

Name: ____Relationship: ______________________

Name: ____Relationship: ______________________

Name: ____Relationship: ______________________

Name: ____Relationship: ______________________

Signature: ____ Date: __________________

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Assignment of Benefits: I request that payment of authorized Medical Benefits be made on my behalf to North Shore Infectious Diseases Consultants, P.C. for services furnished to me by the provider.
The above named physician may use my health care information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Patient's Name: ____

Patient's Signature: ____

Medicare: The provider has agreed to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, 20% coinsurance, and non-covered services.

Patient's Signature: ____

Participating HMO/PPO: You are responsible for providing your insurance information, insurance card, co-payments, and referral (if required by your carrier).

I understand that if a valid referral is required by my insurance plan from my primary care physician, and it is not received by this office, I will be responsible for payment of the services rendered to me.

Patient's Signature: ____

Non-Participating/ Uninsured: Payment for the initial consultation and all follow up appointments is required at the time of service. If requested, we will submit the claim to your insurance company.

You may issue payment by cash, check, Visa, Master Card or Discover Card.

Patient's Signature: ____