Weill Cornell Physicians

Please Note: All information is confidential and will become part of your medical record
Do not leave any boxes empty, mark N/A for not applicable or None if appropriate. **PLEASE PRINT CLEARLY**.

Patient Name:	***Date of Visit:***
Date of Birth:	**Social Security Number:**
Gender **❑ Male ❑ Female**	**Marital Status:** **❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Domestic Partner**
Home Address:	***Home Phone#:*** ***Other Phone#:***
Preferred Email Address:	**Emergency Contact (Name and Phone Number):** **Relationship to Patient:**
PRIMARY INSURANCE CARRIER:	**INSURANCE ID #:**
INSURANCE PHONE #:	**Are you the Primary Insurance policy holder?** **❑ Yes ❑ No**
If <u>No</u>, Please list the Name and Date of Birth of the Policy Holder:	
Does your insurance plan require <u>referrals</u> for specialty visits? ❑ Yes ❑ No	**If <u>YES</u>, do you have a referral for today's visit?** **❑ Yes ❑ No**
SECONDARY INSURANCE CARRIER: ❑ N/A	**INSURANCE ID #:**

Physician and Pharmacy Information
Referring Physician (Name/Phone/ Fax Number): **Were you referred by the above mentioned physician for a Consultation? ❑ Yes ❑ No**
Primary Care Provider (Name/Phone/Fax Number)**: ❑ Same as Referring?**
Preferred Pharmacy (Name/Phone/Fax Number)**:**

ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I certify that all information above is true and correct. I authorize the holder of medical information about me to release to my insurance and, if I am a Medicare patient, to the Centers for Medicare and Medicaid Services and its agents, any information necessary to determine these benefits or the benefits payable for related services. I request that payment of any benefits be made on my behalf to the provider of services. This assignment will remain in effect until revoked by me in writing.
I understand that I am responsible for payment in full for these services including any amounts not paid by my insurance carrier such as Copayments, Deductibles, and other Non-covered services.

I understand that cosmetic and other non-medically necessary services are not covered by my insurance carrier and that I will be financially responsible for any such non-covered services.

_____ _____

Patient Signature **Date**