

Parkway Pain Care & Rehabilitation

PATIENT INFORMATION						
Patient's last name:	First:	Middle:	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Birth Date / /	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Street address:			Social Security no.:		Home phone no.: ()	
P.O. box:	City:	State:		ZIP Code:		
Occupation:	Employer:			Employer phone no.: ()		
Chose clinic because/Referred to clinic by (please check one box):						
<input type="checkbox"/> Family		<input type="checkbox"/> Friend		<input type="checkbox"/> Close to home/work		<input type="checkbox"/> Dr.
				<input type="checkbox"/> Insurance Plan <input type="checkbox"/> Hospital		
		<input type="checkbox"/> Yellow Pages		<input type="checkbox"/> Other		

INSURANCE INFORMATION					
(Please give your insurance card to the receptionist.)					
Person responsible for bill:	Birth date: / /	Address (if different):		Home phone no.: ()	
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Occupation:	Employer:	Employer address:		Employer phone no.: ()	
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Please indicate primary insurance					
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: \$
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					
Name of secondary insurance (if applicable):		Subscriber's name:		Group no.:	Policy no.:
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ()	Work phone no.: ()
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.			
_____ Patient/Guardian signature			_____ Date

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