FH Medical Care
*Leading with Innovation*

41C West Merrick Rd, Suite 3
Valley Stream, NY 11580
Ph: (516) 599-5600
Fax: (516) 599-5610

# New Patient Information

| **How did you hear about our practice?** | |
|---|---|

## Patient Contact Information –

Patient Name: _____ Date: _____
First Last MI

Social Security #: _____ Date of Birth: _____ Gender: _____

Phone # (Home): _____ (Cell):_____ (Work):_____

Email: _____

Home Address:_____
Street Apartment #

_____
City State Zip Code

Race: _____ Ethnicity:_____

May we contact you via voice message regarding your health, treatment, results, and payment?
❑Home ❑Cell ❑Work

May we contact you via text message regarding your upcoming appointments? ❑Yes ❑No

May we email you at the address stated above regarding your medical care? ❑Yes ❑No

Do you wish to sign up for our online patient portal? ❑Yes ❑No

## Emergency Contact –

Name: _____ Phone #: _____

Relationship to patient: _____

## Preferred Pharmacy –

Pharmacy Name:_____ Phone #: _____

Address:_____

_____

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## Insurance/Financial Information –

### Primary Insurance

Policy Holder Name: _____
First Last MI
Subscriber/Member ID: _____ Group #: _____
Patient's Relationship to Insured: ❑Self ❑Spouse ❑Child ❑Other
Insurance Company: _____ Payer ID: _____
Health Plan Name/ #: _____

### Secondary Insurance

Policy Holder Name: _____
First Last MI
Subscriber/Member ID: _____ Group #: _____
Patient's Relationship to Insured: ❑Self ❑Spouse ❑Child ❑Other
Insurance Company: _____ Payer ID: _____
Health Plan Name/ #: _____

## Patient Financial Responsibility Policy –

Thank you for choosing **FH Medical Care**! We are committed to providing you with the highest quality of care. We ask that you read and sign this to acknowledge your understanding of our patient financial policies. You are ultimately responsible for the payment of treatment and care. The office will bill your insurance for you. However, you, the patient or guardian, are required to provide the most correct and updated information regarding medical insurance. You are also financially responsible for any deductible, co-insurance or any noncovered services.
Co-payments and any deductibles are due at time of service. In the event that your medical insurance plan determines a service to be "not payable", you will be responsible for the complete charge and agree to pay the costs of all services provided. If you are uninsured, you are responsible to pay for any services provided at the time of service. Any overdue statements are due 30 days from receipt of billing.

By signing below, I verify that I have provided the most accurate information in this intake form. I fully understand and agree to the provisions stated above until cancelled by me in writing.

Patient Signature: _____ Date:_____