Blair S. Lewis, M.D., P.C. **1067 Fifth Avenue** **New York, N.Y. 10128**

Last Name _____First Name _____ Middle Name _____

Home Address (Street) _____ (Apt. #) _____

(City,State,Zip)_____

Home Phone ( ) _____ - _____ Cell Phone ( ) _____ - _____

Social Security # _____ Date Of Birth _____/_____/_____ Age:_____

Race (required to ask by Federal Government): American Indian, Asian, Asian Indian, European, Filipino, Japanese, Korean, Hawaiian, White, Other:_____
Decline to answer

Ethnicity: (Circle One) Central American, Cuban, Dominican, Hispanic, Latin American, Mexican, Puerto Rican, South American, Spaniard, Not Hispanic

Email _____ Sex *(Circle)* Male Female Marital Status: S M D Wid Dp

Occupation_____ Employer _____Phone ( ) _____ - _____

Insurance Information

Primary Carrier_____ Insurance #_____

Whose Name Is The Policy In?_____ Date Of Birth _____/_____/_____

Secondary Carrier_____ Insurance #_____

Whose Name Is The Policy In?_____ Date Of Birth _____/_____/_____

Physicians To Whom Reports Are To Be Sent

1) Name:_____ Tel ( ) _____ - _____

Address:_____

2) Name:_____ Tel ( ) _____ - _____

Address:_____

Pharmacy Information

Rx Name: _____ Rx Telephone or Address_____

Have You Or A Family Member Been Treated By Dr. Lewis Before? Yes No

If Yes, Name_____ Relationship_____

"I Verify The Accuracy Of The Above Information And I Authorize The Release Of Information As Provided On The Back Page Of This Form."

Patient's Signature_____Date:_____

RELEASE OF INFORMATION

I hereby authorize my physician, health care practitioner, hospital, clinic or other medical or medically related facility to furnish any and all records, medical history, services rendered or treatment given to me or any dependent for purposes of review, investigation or evaluation of any claim submitted to any insurer.

I also authorize any insurer to disclose to a hospital or health care service plan, self-insurer, or an insurer any medical information obtained if such disclosure is necessary to allow the processing of any claim.

I also allow "medication download" which is a list of any medications I have obtained through my insurance carrier.

If my coverage is under a Group contract held by an employer, an association, trust fund, union or similar entity, this authorization also permits disclosure to them for purposes of utilization review or audit.

This authorization shall become effective immediately upon execution and shall remain in effect for the duration of any claim or term of coverage with any insurer including a reasonable time thereafter until its final consummation. This authorization shall be binding upon me, my dependents, and my heirs, executors and administrators.