Michael Mesbah, MD **Karyn Wat, MD**
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877 Stewart Avenue • Suite 3 • Garden City, NY 11530 • 516-794-1500

PATIENT INFORMATION

Thank you for choosing our office! It is imperative we have all your updated information on file. Please fill out form COMPLETELY. All information will be kept confidential. **PLEASE PRINT.**

Whom may we thank for referring you?_____ Date:_____

Name:_____ DOB:_____ Age:_____

Home Address:_____ SS#:_____

City:_____ State:_____ Zip Code:_____

Home Phone #:_____ Cell:_____ Work:_____

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ Separated ❑ Minor

Patient Email Address:_____

Person to contact in case of emergency:_____ Phone #:_____

Patient Employer:_____

Work Address:_____

City:_____ State:_____ Zip Code:_____

As of March 2015, it is mandated that all prescriptions are done electronically. We will no longer be able to call in any prescriptions. Please supply complete pharmacy information.

Pharmacy Name:_____ Phone number:_____

Address:_____

INSURANCE INFORMATION

Name of Insurance Co:_____ Insurance ID:_____

Insurance Address:_____ Group No:_____

Policyholder Name:_____ Relationship to patient:_____ DOB:_____

Address:_____ City/State:_____ Zip code:_____

Name of employer:_____ Home phone #:_____ Work:_____

IF YOU HAVE A SECONDARY INSURANCE, PLEASE COMPLETE THE FOLLOWING INFORMATION

Name of Insurance Co:_____ Insurance ID:_____

Insurance Address:_____ Group No:_____

Policyholder Name:_____ Relationship to patient:_____ DOB:_____

Address:_____ City/State:_____ Zip code:_____

Name of employer:_____ Home phone #:_____ Work:_____

I authorize release of any information concerning my (or my child's) healthcare, advice and treatment provided for the purpose of evaluating and administrating claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my (child's) account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

_____ _____

Signature of patient or parent/guardian if minor Date