Patient Intake Form

141 Little East Neck Road
West Babylon, NY 11704
T: (631) 321-1045
F: (631) 321-1102

dr-polcino.com

Today's Date: Have you been to Dr. Polcino's in the last 3 years? Yes No

PATIENT INFORMATION

First Name: ______ Last Name: ______

Address: ______ City: ______ Zip: ______

Email: ______

Date of Birth: ______ Marital Status: S M W D

Home phone #: ______ Cell #: ______

EMPLOYER INFORMATION

Employer Name: ______ Work #: ______

PHYSICIAN INFORMATION

Primary Care Physician: ______ Physician Phone #: ______

Physician Address: ______ City: ______ Zip: ______

PHARMACY INFORMATION

Pharmacy Name: ______ Pharmacy Phone #: ______

Address: ______ City: ______ Zip: ______

MEDICAL INSURANCE INFORMATION

Name of Policy Holder: ______ Relationship: ______

Policy Holder's Employer: ______

Date of Birth of Insured (leave blank if patient is policy holder): ______

Insurance Company: ______

Policy #: ______ Group: ______

Do you have secondary insurance? Yes No

I, the undersigned, have insurance with ______ and assign directly to Dr. Michael H. Polcino all medical benefits, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits, and authorize the use of this signature on all of my submissions. **I am aware that I will be responsible for any laboratory or radiological charges not covered by my insurance company.**

Patient Signature: Date: