MEDICAL RECORD# _____

NAME: **LAST** _____ **FIRST** _____

ADDRESS _____APT# #_____

_

CITY _____STATE_____ZIP_____

PHONE Home _____ **Cell** _____ **Wor k**_____ **Fax** _____

PREFERRED METHOD(S) OF CONTACT (circle all that apply) Home Cell Business

LOCATION(S) TO LEAVE MESSAGES (circle all that apply) Home Cell Business

Please circle: Married Single Domestic partner Widowed Divorced

LOCAL PHARMACY Name/Phone/Address _____

MAIL ORDER PHARMACY Name/Phone _____

SOCIAL SECURITY # _____ DATE OF BIRTH _____

MOTHER'S FIRST NAME_____FATHER'S FIRST NAME_____

EMPLOYER NAME/ADDRESS_____

OCCUPATION_____

REFERRED BY_____PHONE NUMBER_____

SPOUSE/PARTNER INFORMATION:

NAME _____ SOCIAL SECURITY # _____

DATE OF BIRTH _____ BUSINESS PHONE# _____

INSURANCE INFORMATION:

PRIMARY INSURANCE COMPANY NAME/ADDRESS _____

INSURANCE POLICY HOLDERS NAME _____

DOB_____ SS _____

INSURANCE ID # _____ GROUP# _____

SECONDARY INSURANCE COMPANY NAME/ADDRESS _____

INSURANCE POLICY HOLDERS NAME _____

INSURANCE ID # _____ GROUP #_____

By signing this form I understand that: 1) the medical practice of Dr. Matera, Moomjy and Brown has opted out of Medicare in January 2006, 2) this practice is only contracted with UnitedHealth for Columbia University employees, 3) for all other patients, full payment is due on the day that the services are rendered, 4) a 1.33% monthly finance charge will be applied to all accounts that are 60 days overdue, 5) it is my responsibility to follow-up with my insurance company for reimbursement of a service, even if the submission is performed by MWHF, 6) it is my responsibility to ensure that any necessary precertification has been obtained from my insurance company for services that require it, and 7)I understand that physician referrals may not participate in my insurance plan. Finally, I acknowledge that I was provided with the HIPAA Notice of Patient Privacy practices and the Office Financial Policy for this medical practice.

SIGNATURE _____ DATE _____