MEDICAL RECORD#_____

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

ADDRESS_____APT#_____

CITY_____STATE_____ZIP_____

HOME PHONE #_____BUSINESS PHONE #_____

CELL PHONE #_____BEEPER #_____

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

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

HOME FAX # _____WORK FAX # _____

Please circle: Married Single Domestic partner Widowed Divorced

PHARMACY NAME AN PHONE NUMBER #_____

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 #_____

I understand that the medical practice of Dr. Matera, Moomjy and Brown has opted out of Medicare as of January 1, 2006. The only insurance plan that the practice is contracted with is the UnitedHealth for Columbia University employees. For all other patients, full payment is due on the day that the services are rendered and a 1.5% monthly finance charge will be applied to all accounts that are 60 days overdue. *I also understand that it is my responsibility to follow-up with my insurance company for reimbursement of a service*, even if the submission is performed by MWHF.
I acknowledge that I was provided with a copy of the Office Financial Policy and the HIPAA Notice of Patient Privacy practices for this office.

SIGNATURE_____DATE_____