

**BETH ISRAEL LATINO HEALTH INSTITUTE / ITZAMNA MEDICAL CENTER**  
**359 SECOND AVENUE**  
**NEW YORK, NY 10010**  
**212-420-9225**

Date \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

**Patient Information**

Last Name _____	First Name _____	Mid. Initial _____	SS/HIC Patient ID # _____
Address _____			E-mail _____
City _____	State _____	Zip _____	Married _____
Sex    Male    Female	Age _____	Birth Date _____	Separated _____
Patient Employer or School _____			Widowed _____
Employer or School Address _____			Divorced _____
In case of emergency who should be notified? _____			Partnered for _____ years
Whom may we thank for referring you? _____			Single _____
			Minor _____
			Occupation _____
			Employer/School Phone _____
			Emergency Phone _____

**Primary Insurance**

Person Responsible for Account				
Last Name _____	First Name _____	Mid. Initial _____	Relation to Patient _____	
Address (if different from patient's) _____			Soc. Sec. # _____	
City _____	State _____	Zip _____	Birth Date _____	
Person Responsible Employed by _____			Phone _____	
Business Address _____			Occupation _____	
Business Phone _____			Names of other dependents covered under plan	
Insurance Company _____			_____	
Contract # _____			Group # _____	Subscriber # _____

**Additional Insurance**

Is patient covered by additional insurance?    Yes    No			
Subscriber Name _____	Birth Date _____	Relation to Patient _____	
Address (if different from patient's) _____		Soc. Sec. # _____	
City _____	State _____	Zip _____	Phone _____
Subscriber Employed by _____		Business Phone _____	
Insurance Company _____		Names of other dependents covered under plan	
Contract # _____		Group # _____	Subscriber # _____

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**Assignment and Release**

I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_ and assign directly to Dr. \_\_\_\_\_ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named doctor may use my health care information and may disclose such information to the above named insurance company (or companies) and its/their agents for the purposes of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative \_\_\_\_\_ Date \_\_\_\_\_

Please print name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_