THE ROGOSIN INSTITUTE
Centers For Medical Research And Health Care

The Rogosin Institute
New or Updated Patient Information

Tax I.D. No: 13-3184198 **NYH Medical Record #:** ______________________

Medicare I.D. No: W08421 **MIQS #:** ______________ ADS#: ______________

PATIENT INFORMATION:

This is a confidential record, and information contained within will not be released except when you have authorized us to do so.

NAME: **(Last)** **(First)** **(Middle Initial)**

ADDRESS: **(Street & Number)**

(City) **(State)** **(Zip Code)** **(Apt. No.)**

PHONE: **(Home/Cell Phone)** **(Business Phone)** **BIRTH DATE:**

SSN: ________________ **SEX:** ___ M ___ F **PLACE OF BIRTH:** ________________________________

MARITAL STATUS: ________________ **RELIGION:** ________________

RACE: ___ WHITE ___ BLACK ___ HISPANIC ___ ASIAN ___ NATIVE AMERICAN ___ OTHER ___________

FATHER'S NAME: _________ **MOTHER'S MAIDEN NAME:** _________ **SPOUSE'S NAME:** __________

EMERGENCY:

Contact Name: _________________ **Phone:** _________________ **Relationship to Patient:** _________________

PRIMARY OR REFERRING PHYSICIAN:

Physician Name: ____________________________

Address: ____ **Phone:** ______________ **Fax:** ______________

City: ______________ **State:** ______________ **Zip:** ______________

PATIENT EMPLOYER:

Name: ____________________________**Address:** ____

City: ______________ **State:** ______________ **Zip:** ______________ **Phone:** ______________

INSURANCE INFORMATION:
Primary Insurance

Name: ____________________________ **Policy #:** __________________________ **Group #:** __________________________

Address: ____ **Phone:** ______________

City: ______________ **State:** ______________ **Zip:** ______________ **Co-Payment:** ________________________

PATIENT NAME: ____________________

Primary Insurance Holder:

Last Name: ____________________ **First Name:** ____________________

Address: ____________________ **Phone:** ______________

City: ______________ **State:** ______________ **Zip:** ______________

SSN: ____________________ **SEX:** ___ **M** ___ **F** **Date of Birth:** ____________________

Relationship to Patient: ___ **Self** ___ **Spouse** ___ **Dependant** ___ **Other** ____________________

Employer Name: ____________________ **Phone:** ____________________

Secondary Insurance (if applicable):

Name: ____________________ **Policy #:** ____________________ **Group #:** ____________________

Address: ____________________ **Phone:** ______________

City: ______________ **State:** ______________ **Zip:** ______________ **Co-Payment:** ____________________

Secondary Insurance Holder:

Last Name: ____________________ **First Name:** ____________________

Address: ____________________ **Phone:** ______________

City: ______________ **State:** ______________ **Zip:** ______________

SSN: ____________________ **SEX:** ___ **M** ___ **F** **Date of Birth:** ____________________

Relationship to Patient: ___ **Self** ___ **Spouse** ___ **Dependant** ___ **Other** ____________________

Employer Name: ____________________ **Phone:** ____________________

Assignment of Benefits: **I assign all medical and/or surgical benefits to which I am entitled including major medical, Medicare, Medicaid, Private insurance and any other health plans to THE ROGOSIN INSTITUTE. This agreement will remain in effect until revoked by me in writing. Photocopy of this assignment is to be considered as valid as an original. I understand I am financially responsible for any deductible amount, co-insurance, or any other balance not paid by my insurance. I hereby authorize THE ROGOSIN INSTITUTE to release all information as necessary to secure payment.**

PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED

Signature: ______________________________ **Date:** ____________________

Rev. Billing Dept.