ALLERGIES

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DR. SCOTT BROWN
DR. KEITH LEVENTHAL
NU IMAGE MEDICAL ASSOCIATES, L.L.P.
2374 JERUSALEM AVENUE
NO. BELLMORE, NY 11710
(516) 409-8311 FAX (516) 409-8313

FOR OFFICE USE ONLY:

ICD-9_____

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_____

_____

Home Phone (____)_____

Business Phone (____)_____

Cell Phone (____)_____

Emergency Contact Phone (____)_____

E-mail Address_____

Date Initially Seen_____

Name_____(first)_____(intial)_____Soc. Sec.#_____

Address_____

City_____State_____Zip_____

Sex ☐ M ☐ F Age_____ Date of Birth_____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

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Employer_____Occupation_____

Business Address_____Business Phone (___)_____

Whom may we thank for referring you?_____

In came of emergency name 2 people to be notified? (1)_____Phone (___)_____

(2)_____Phone (___)_____

PRIMARY INSURANCE_____ID #_____

Policyholder (last)_____(first)_____(initial)_____

Relationsihp to Patient_____Birthdate_____Soc. Sec.#_____

Policyholder's Employer_____

SECONDARY INSURANCE_____ID #_____

Policyholder (last)_____(first)_____(initial)_____

Relationsihp to Patient_____Birthdate_____Soc. Sec.#_____

OTHER INSURANCE_____ID #_____

The undersigned certify that I (or my dependent) have insurance coverage with _____

NAME OF INSURANCE COMPANY (IES)

and assign directly to _____all insurance benefits, if any otherwise payable to me for services rendered. lunderstand thet I am financlally responsible for and will pay all charges whether or not covered by insurance. I understand that some services may not be authorized by and may not be covered under my insurance. I hereby authorizethe doctor to release all information necessary to secure the payment of benefits. t authorize the usa of this signature on all insurance submissions.

_____ _____

Print Name Signature Date