EAST COAST RHEUMATOLOGY, PLLC
PREM C. CHATPAR, M.D., LLC & ASSOCIATES

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877 Stewart Avenue Ste. 16
Garden City, New York 11530
(516) 745-0202

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Huntington Station, NY 11746
(631) 629-4588

PATIENT INFORMATION & CONTACT

NAME: ______________________________ HOME PHONE: ______________
ADDRESS: ______________ WORK PHONE: __________ CELL PHONE: ______________
CITY: ______________ STATE: ________ ZIP CODE: ______________
D.O.B.: ___/___/___ AGE: ____ STATUS: S M W D EMAIL ADDRESS: ______________
EMPLOYER: ______________ S.S. No: __________ SEX: ____ **Referring M.D. or P.C.P** ______________
EMERGENCY CONTACT ______________________ TEL NO: ______________

RESPONSIBLE PARTY (INSURED) INFORMATION
(IF SAME, WRITE SAME)

NAME: ______________________________ HOME PHONE: ______________
ADDRESS: ______________________________ WORK PHONE: ______________
CITY: ______________ STATE: __________ ZIP CODE: ______________
D.O.B.: ___/___/___ S.S. No.: __________ SEX: ______________
EMPLOYER: ______________________ PATIENT RELATIONSHIP: ______________

INSURANCE INFORMATION

PLEASE PROVIDE ALL INSURANCE CARDS AND **COMPLETE THE FOLLOWING INFORMATION:**

PRIMARY:

INSURANCE NAME: ______________ INSURED PARTY: ______________
ADDRESS: ______________ INS. ID No.: ______________
____

SECONDARY:

INSURANCE NAME: ______________ INSURED PARTY: ______________
ADDRESS: ______________ INS. ID No.: ______________
____

How would you prefer we contact you? Please be very specific. If we can leave a message and with whom. **Please choose two method of contact.**
You may / may not call me at home number ______________
You may / may not leave a message on my answering machine.
You may leave a message with (please circle) no one, my spouse, my children, other, ______________
You may / may not call me at work number ______________
You may / may not leave a message on my voicemail ______________
You may / may not call me on my cell phone number ______________
You may / may not leave a message on cell phone ______________
You may / may not fax me at number ______________
You may call my preferred pharmacy for prescriptions at number ______________

PATIENT OR AUTHORIZED SIGNATURE (REQUIRED): ______________ **DATE:** __________ **2016**