PREM C.CHATPAR, M.D., LLC & ASSOCIATES

524 Old Country Road
Plainview, NY 11803
(516) 931-3988

877 Stewart Ave Ste. 16
Garden City, NY 11530
(516) 745-0202

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: ______________________ INSURANCE PARTY: ______________________

ADDRESS: ______________________ INS. ID No.: ______________________

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SECONDARY:

INSURANCE NAME: ______________________ INSURANCE PARTY: ______________________

ADDRESS: ______________________ INS. ID No.: ______________________

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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: ______________ 2021

NEWPT 01-2021