NAME: _____

BIRTHDATE: _____ SS# _____

ADDRESS: _____

CITY: _____ STATE: _____

ZIP CODE: _____ HOME PHONE: _____

WORK PHONE: _____ MAY WE CONTACT YOU AT WORK? Y N

CELL PHONE: _____ OCCUPATION: _____

EMAIL: _____ SEX: M F MARITAL STATUS: M S D W

PRIMARY INSURANCE COMPANY: _____

POLICY NUMBER: _____ GROUP NUMBER: _____

POLICY HOLDER NAME: _____ POLICY HOLDER DOB: _____

POLICY HOLDER SS# _____ RELATIONSHIP TO INSURED: _____

POLICY HOLDER EMPLOYER: _____

SECONDARY INSURANCE COMPANY: _____

POLICY NUMBER: _____ GROUP NUMBER: _____

POLICY HOLDER NAME: _____ POLICY HOLDER DOB: _____

POLICY HOLDER SS# _____ RELATIONSHIP TO INSURED: _____

POLICY HOLDER EMPLOYER: _____

EMERGENCY CONTACT: _____

RELATIONSHIP: _____ PHONE#: _____

We require 24 hours notice for an appointment cancellation. If notice is not received, you will be subject to a $50 fee. There is also a $10 administrative fee for copays not paid at the time of service.

I authorize my physician to mark the section "ENROLLEE'S OR AUTHORIZED PERSON'S SIGNATURE" with the notation "SIGNATURE ON FILE". This authorizes the release of medical information to my insurance carrier or other third party which is necessary to process medical claims. It also authorizes payment of medical benefits directly to the physician.

_____ _____

PATIENT'S SIGNATURE DATE

LOCAL PHARMACY: _____ PHONE#: _____

ADDRESS: _____

MAIL ORDER PHARMACY: _____ PHONE #: _____

ADDRESS: _____

By signing this consent form you are agreeing that Eastern Long Island Family Medicine can request, view, and use your prescription medication history from other healthcare providers and third parties such as, but not limited to, pharmacies, benefit payers, and government databases.

Understanding all of the above, I hereby provide informed consent for Eastern Long Island Family Medicine to obtain my prescription history.

_____ _____

Signature Date

NYSIIS (New York State Immunization Information System)

We are required to report all immunizations given to anyone under the age of 18 to NYSIIS. Those 18 and older require us to collect authorization from the patient.

I give Christopher Ng M.D. and Eastern Long Island Family Medicine consent to report any immunizations administered to the New York State Immunization Information System.

_____ _____

Signature Mothers maiden name (optional, for identification purposes)

MEDICARE PATIENTS ONLY:

Eastern Long Island Family Medicine participates in a Medicare Shared Savings Program Accountable Care Organization. ACOs are groups of doctors and other health care providers who voluntarily work together with Medicare to give you high quality service and care at the right time in the right setting. An ACO is not a Medicare Advantage Plan, or an insurance plan. ACOs don't change your Medicare benefits. To help you get better, more coordinated care, Medicare will share certain health information with us about the care you get from your doctors and other health care providers.

Initial here to acknowledge that you are aware of our participation in an ACO: _____