New York Primary Care
THE CHABLA FAMILY PRACTICE
Office: 212-568-8400 Fax: 212-927-5719

Make an appointment Today
639 W 185th Street
New York, NY 10033
www.nypcare.com

NEW PATIENT FORM:

Patient's Name: _____

Marital Status: _____ Age _____ Male/Female: _____

Social Security Number: _____ Date Of Birth: _____

Email: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone Number: ( ) _____ Cell Phone Number: ( ) _____

Employer: _____

Occupation: _____ Work Number: ( ) _____

Do you have a Healthcare Proxy: Yes No

PHARMACY INFORMATION:

Preferred Pharmacy: _____ Phone Number: ( ) _____

Address: _____

City: _____ State: _____ Zip Code: _____

IF PATIENT IS A MINOR OR STUDENT:

Mother's Name: _____

Date of Birth: _____ Social Security Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: ( ) _____

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Father's Name: _____

Date of Birth: _____ Social Security Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: ( ) _____

INSURANCE INFORMATION:

Primary Insurance Company: _____ ID#:_____

Group Number: _____

Policy Holder's Name: _____

Date of Birth: _____ Social Security Number: _____

Employer: _____

Secondary Insurance Company: _____ ID#:_____

Group Number: _____

Policy Holder's Name: _____

Date of Birth: _____ Social Security Number: _____

Employer: _____

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EMERGENCY CONTACT:

Name: _____ Relationship:_____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: ( ) _____

CONSENT AND AUTHORIZATION: I hereby give my consent and authorization for *New York Primary Care Medicine, P.C* to use or disclose my personal health information as they see fit. I understand I have the right to review the provider's privacy notice, to request restrictions and to revoke this consent at any time. This consent and authorization is valid for *New York Primary Care Medicine, P.C I* also authorize and request that payment under my insurance programs be made directly to the above provider for any services furnished to me. I understand even though I have insurance, I am responsible for payment.

Signed _____ Date:_____