Drs.Maklansky, Kurzban, Cohen, Zimmer, Hyman, Berson, Maklansky, Mester, and Mecca
NYMI Associates PC 165 East 84th st. New York NY 10028 Tel. (212) 535-9770 Fax (212) 988-1520

PATIENT INFORMATION Account

Name _____
Last First Initial

Address _____
Street City State Zip

SS# _____ Sex M☐ F☐ Birth Date _____ Age _____ Marital Status Choose _____

Home Phone (___)_____Cell Phone (___)_____ Work Phone (__)_____

Referring Physician _____ Phone # _____

Referring Physician #2 _____ PATIENT EMAIL ADDRESS:

ELECTRONIC MEDICAL RECORD INFORMATION

- What is your race/ethnicity_____ Native language spoken _____
- Smoking Status (please circle one): Never ☐ Sometimes ☐ Every Day ☐ Former ☐
- List of Current Medications_____
  _____
- Please provide list of Medication Allergies _____
  _____
- Please provide a list of current conditions _____
  _____

INSURANCE INFORMATION

Primary Insurance Carrier_____ Phone (___)_____

Policy Number _____ Group Number _____
Policy Holder _____ Date of Birth _____ Relationship _____

Secondary Insurance Carrier_____ Phone (___)_____

Policy Number _____ Group Number _____
Policy Holder _____ Date of Birth _____ Relationship _____

I authorize payment directly to NYMI Associates on my behalf for services rendered by them. I also authorize them to release any information needed to determine these benefits. I understand that I am responsible for payment of their services if full payment is not made by the insurance carrier.

Date_____ Signature_____