



1400 Route 300
Newburgh, NY 12550

PATIENT INFORMATION SHEET

PLEASE PRINT CLEARLY AND COMPLETE ALL ITEMS THAT APPLY. **Date:** _____

GENERAL

Patient name: **Last:** _____ **First:** _____ **Middle:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

SS#: _____ - _____ - _____ Telephone: **Home:**(____) - _____ - _____ work:(____) - _____ - _____

[] Single [] Married [] Widowed [] Divorced [] Separated **Sex:** [] Male [] Female

Date of Birth: ____ / ____ / ____ **Age:** ____ years old **Guarantor:** _____ Relationship _____

E-mail: _____ @ _____ Pager / Cellular: (____) - _____ - _____

Emergency Contact: _____ Relationship: _____ Telephone: _____ Alternate: _____

Referring Physician: _____ **Primary Care Physician:** _____ [] OMNI, Dr. Kay [] None

How did you hear about us? [] Physician [] Newspaper [] Yellow pages [] Walked by Office

[] Other: _____ [] Friend/Relative Name: _____ Address: _____

EMPLOYER / AGENCY

Employer: _____ **Occupation:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Agency (if applicable): _____ [] EMS [] FD [] PD

INSURANCE

Primary Insurance Company: _____ **ID #:** _____ **Group #:** _____

Address: _____

Policy Holder: _____ **Relationship:** _____ **Date of Birth:** _____ **SS #:** _____ - _____ - _____

Secondary Insurance Company: _____ **ID #:** _____ **Group #:** _____

Address: _____

Policy Holder: _____ **Relationship:** _____ **Date of Birth:** _____ **SS #:** _____ - _____ - _____

Authorization to Release Information and Assignment of Benefits

I understand that I am financially responsible for all charges incurred for services and supplies, whether or not paid by said insurance. I authorize the release of any and all information necessary to process this claim and secure the payment. I permit a copy of this authorization to be used in place of the original. I certify that the information I have reported is correct. I hereby authorize payment to Dr. Kay or OMNI Medical Care for medical benefits on my behalf. I request that payment be made directly to Glen S. Kay, M.D., P.C. or OMNI Medical Care.

[] My agency, as listed above, has sent me and they are responsible for the charges.

Treatment Authorization

I authorize the performance of medically necessary diagnostic tests, treatment, and procedures upon myself / my child by Dr. Kay, his designee and / or OMNI Medical Care.

Signature: _____ [] Parent / Guardian **Date:** ____ / ____ / ____