WILLIAM PURTILL, M.D.
990 Stewart Avenue
Suite L32
Garden City, NY 11530

PATIENT INFORMATION:

Last Name: _____ First Name: _____ Middle Name: _____ Sex: M: __ F: __

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Marital Status: _____

SS #:_____ Cell/beeper#: _____ Religion (optional): _____

Date of Birth: _____ Race (optional): _____

Emergency Contact: _____ Phone#: _____ Relationship: _____

Primary Physician: _____ Primary Phone: _____

Primary Address: _____

Referring Physician: _____ Referring Phone: _____

Referring Address: _____

INSURANCE INFORMATION

Primary Insurance: _____

Insured Name: _____ Relationship: _____ HMO: Y: ___N: ___ Sex: M: ___ F: ___

Insured ID #: _____ Group#: _____ Insured Date of Birth: _____

Insured SS#:_____ Insured Address: _____

Employer: _____ Employer Address: _____

Secondary Insurance: _____

Insured Name: _____ Relationship: _____ HMO: Y: ___ N: ___ Sex: M: ___ F: ___

Insured ID #_____ Group: _____

Insured SS#_____ Insured Address: _____

PHARMACY INFORMATION

Pharmacy Name: _____ Pharmacy Phone: _____

Pharmacy Address: _____

AUTOMOBILE AND WORK INJURY PATIENTS ONLY:

Please circle: Work Injury Auto Injury

Employer (work injury only): _____ Auto Policy holder (auto injury only): _____

Injury date: _____ Insurance Co.: _____ Insurance Phone: _____

Insurance address: _____

Case #: _____Policy #: _____

PATIENT VERIFICATION SIGNATURE:

I verify the accuracy of the above information and I authorize the release of information necessary to determine liability for payment and to obtain reimbursement. I assign benefits to William Purtill, MD, PC.

WILLIAM PURTILL, M.D.
990 Stewart Avenue
Suite L32
Garden City, NY 11530

PATIENT OR AUTHORIZED SIGNATURE: _____ Date: _____