

WELCOME TO...

*Dr. Ratner's Office
407 Franklin Avenue
Franklin Square, New York 11010*

FOR OFFICE USE ONLY: **CHART #** _____ **SOF/LOR:** _____

TODAY'S DATE: _____ **REFERRED BY:** _____

WHO IS YOUR primary care physician (PCP)? _____

~~~~~  
*Last Name:* \_\_\_\_\_ *First Name:* \_\_\_\_\_ *Middle Initial:* \_\_\_\_\_

*Street Address:* \_\_\_\_\_

*City:* \_\_\_\_\_ *State:* \_\_\_\_\_ *Zip Code:* \_\_\_\_\_

*Male*    *Female*    *Date of Birth:* \_\_\_\_\_      *Social Security #:* \_\_\_\_\_

*Home Telephone #:* \_\_\_\_\_      *Work Telephone #:* \_\_\_\_\_

*Employer or School:* \_\_\_\_\_

*Marital Status:*   *SINGLE:* \_\_\_ *MARRIED:* \_\_\_ *OTHER:* \_\_\_      **IN CASE OF AN EMERGENCY - CONTACT NAME & TELEPHONE #:** \_\_\_\_\_

~~INSURANCE INFORMATION~~

**PRIMARY Insurance Company:** \_\_\_\_\_

*Address:* \_\_\_\_\_ *Policy #:* \_\_\_\_\_

*Group #:* \_\_\_\_\_ *Policy Holder's Name:* \_\_\_\_\_ *Relationship:* \_\_\_\_\_

*Policy Holder's DOB:* \_\_\_\_\_ *Employer:* \_\_\_\_\_ *Local/Union:* \_\_\_\_\_

**SECONDARY Insurance Company:** \_\_\_\_\_

*Address:* \_\_\_\_\_ *Policy #:* \_\_\_\_\_

*Group #:* \_\_\_\_\_ *Policy Holder's Name:* \_\_\_\_\_ *Relationship:* \_\_\_\_\_

*Policy Holder's DOB:* \_\_\_\_\_ *Employer:* \_\_\_\_\_ *Local/Union:* \_\_\_\_\_

*Please complete our financial / authorization form (on reverse side).*

Thank You.