



...Where Patients Come **FIRST**

(716) 631-2500

APPOINTMENT TIME: \_\_\_\_\_ LOCATION: \_\_\_\_\_ DATE: \_\_\_\_\_

NEW PATIENT  CHANGE OF INFORMATION

**PATIENT INFORMATION - Please print legibly**

MR MS MRS MISS	FIRST NAME	MIDDLE INITIAL	LAST NAME		MAIDEN NAME	
STREET			APT. NO.	ZIP CODE	CITY	STATE
HOME PHONE ( ) ( )			WORK PHONE ( ) ( )			BIRTH DATE
SOCIAL SECURITY #		SEX	MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED			
IF MARRIED - NAME OF SPOUSE			NAME AND ADDRESS OF REFERRING PHYSICIAN			
IF MINOR, NAME OF PARENT / GUARDIAN			PHONE	ADDRESS		
NAME OF PERSON TO CONTACT IN AN EMERGENCY			PHONE	ADDRESS		

DO YOU HAVE A LATEX SENSITIVITY OR ALLERGY?  YES  NO

**EMPLOYMENT INFORMATION**

PATIENT'S EMPLOYER		SPOUSE OR PARENT / GUARDIAN'S EMPLOYER	
ADDRESS	CITY	ADDRESS	CITY
STATE & ZIP CODE	PHONE	STATE & ZIP CODE	PHONE

**INSURANCE INFORMATION (If related to NO FAULT or WORKERS' COMPENSATION see below)**

We are pleased to offer our patients the courtesy of participation with several insurances:

- |                        |              |                            |                       |
|------------------------|--------------|----------------------------|-----------------------|
| BCBS OF WNY            | FIRST HEALTH | MULTIPLAN                  | RAILROAD MEDICARE     |
| BEECH STREET           | GHI          | MUTUAL OF OMAHA            | RMSCO-Excellus        |
| BFLO. COMMUNITY HEALTH | IHA          | NYS NO FAULT               | SENIOR BLUE           |
| CHOICE BLUE OF WNY     | MAGNACARE    | N. AMERICAN ADMINISTRATORS | SENIOR CHOICE         |
| COMMUNITY BLUE         | MEDFOCUS     | NOVA                       | UNIVERA               |
| EMPIRE-METRAHEALTH     | MEDICAID     | PRUDENTIAL                 | WORKERS' COMPENSATION |
| FIDELIS                | MEDICARE     |                            |                       |

NAME OF PRIMARY INSURANCE COMPANY			NAME OF SECONDARY INSURANCE COMPANY		
ADDRESS			ADDRESS		
CITY	STATE	ZIP CODE	CITY	STATE	ZIP CODE
GROUP #	POLICY #		GROUP #	POLICY #	
NAME OF SUBSCRIBER			NAME OF SUBSCRIBER		
RELATIONSHIP TO PATIENT <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> FATHER <input type="checkbox"/> MOTHER <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER			RELATIONSHIP TO PATIENT <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> FATHER <input type="checkbox"/> MOTHER <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER		

DOES YOUR INSURANCE REQUIRE PRE-AUTHORIZATION FOR YOUR EXAM TODAY?  NO  YES AUTHORIZATION # \_\_\_\_\_

**ACCIDENT / NO FAULT / WORKERS' COMPENSATION INFORMATION**

WHERE DID THE ACCIDENT HAPPEN?  
 HOME  AUTO  WORK

DATE OF ACCIDENT	NAME OF INSURANCE CARRIER		
ADDRESS			
CARRIER CASE #	WORKERS COMP. BOARD CASE #	AUTO POLICY #	AUTO ACCIDENT CLAIM #

- \* PLEASE BRING INSURANCE CARD(S), OFFICE COPAYMENT AND DOCTOR'S ORDERS.
- \* PLEASE ARRIVE 15 MINUTES AHEAD OF TIME UNLESS OTHERWISE SPECIFIED.