NEIL MINIKES, MD

500 PIERMONT ROAD, SUITE 304
CLOSTER, NJ 07624

201•564•7777
201•564•7776 FAX

www.DRMINIKESALLERGY.COM

PATIENT INFORMATION (CONFIDENTIAL)

LAST NAME | FIRST NAME | BIRTHDATE / / | SEX ◯ M ◯ F | OCCUPATION

ADDRESS | CITY | STATE | ZIP

HOME PHONE # | CELL PHONE # | WORK PHONE # | EMAIL

PRIMARY CARE PHYSICIAN | PHONE # | FAX #

ADDRESS | CITY | STATE | ZIP

REFERRED BY | PHONE #

PHARMACY | PHONE # | FAX #

RESPONSIBLE PARTY (IF MINOR)

FATHER'S LAST NAME | FATHER'S FIRST NAME | BIRTHDATE / / | OCCUPATION

HOME PHONE # | CELL PHONE # | WORK PHONE # | EMAIL

MOTHER'S LAST NAME | MOTHER'S FIRST NAME | BIRTHDATE / / | OCCUPATION

HOME PHONE # | CELL PHONE # | WORK PHONE # | EMAIL

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY | POLICY/ID # | GROUP #

POLICY HOLDER LAST NAME | POLICY HOLDER FIRST NAME | BIRTHDATE / / | RELATIONSHIP TO PATIENT

ADDRESS (IF DIFFERENT THAN ABOVE) | CITY | STATE | ZIP

REFERRAL REQUIRED? | SPECIALIST CO-PAY | DEDUCTIBLE AMOUNT

SECONDARY INSURANCE INFORMATION (IF APPLICABLE)

INSURANCE COMPANY | POLICY/ID # | GROUP #

POLICY HOLDER LAST NAME | POLICY HOLDER FIRST NAME | BIRTHDATE / / | RELATIONSHIP TO PATIENT

ADDRESS (IF DIFFERENT THAN ABOVE) | CITY | STATE | ZIP

REFERRAL REQUIRED? | SPECIALIST CO-PAY | DEDUCTIBLE AMOUNT

ASSIGNMENT OF BENEFITS. I assign all medical benefits to which I am entitled including major medical, Medicare, private insurance and any other health plans to Neil I. Minikes, MD. Photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges not paid by my insurance. I understand that it is the policy of Neil I. Minikes, MD that the charges for all office visits be paid at the conclusion of each visit. I will be responsible to know my own insurance with regard to referrals, the number of visits that have been authorized by my primary care physician, and when my referral expires. If I am seen in this office without a valid referral, I will be financially responsible for the full amount of the services rendered. I hereby authorize said assignee to use my signature for insurance purposes and to release all information necessary to secure payment.

SIGNATURE OF PATIENT (OR PARENT IF MINOR) | DATE