DAVID GERSTENFELD, M.D., F.A.C.S.
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4299 Hylan Boulevard, SI NY 10312 1500 Victory Blvd, SI NY 10301
718-984-7616

PATIENT INFORMATION FORM

DATE______________________________ ☐ **NEW PATIENT**

NAME______________________________ E-MAIL______________________________

SSN ______________________________ OCCUPATION______________________________

DATE OF BIRTH ______________________________ EMPLOYER ______________________________

ADDRESS ______________________________ MARITAL STATUS:________________ SEX: ____________

______________________________ **EMERGENCY CONTACT**

HOME PHONE ______________________________ NAME ______________________________

CELL PHONE______________________________ PHONE______________________________

WORK PHONE______________________________ RELATIONSHIP______________________________

RACE: __ASIAN __NATIVE AMERICAN
__BLACK __2 OR MORE
__CAUCASIAN __OTHER

ETHNICITY:
__HISPANIC
__NOT HISPANIC

REFERRING DOCTOR/PERSON [ ] ______________________________

PRIMARY CARE PHYSICIAN ______________________________

INSURANCE INFORMATION

COPAY ______________________________

PRIMARY ______________________________

SECONDARY ______________________________

POLICY HOLDER (if not patient)______________________________ SSN ______________________________

RELATIONSHIP______________________________ DATE OF BIRTH______________________________

ADDRESS ______________________________CITY/STATE/ZIP ______________________________

HOME PHONE____________________ CELL PHONE____________________ WORK PHONE ____________________

By my signature below, I acknowledge that I have received Island Eye Surgery Specialists notice of Privacy Practices.

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Patient Signature **Date**

I AUTHORIZE RELEASE OF MEDICAL INFORMATION CONCERNING MYSELF OR MY DEPENDENTS FOR THE PURPOSE OF PROCESSING CLAIMS FOR INSURANCE BENEFITS. I HEREBY ASSIGN TO THE PHYSICIAN ALL PAYMENTS FROM MY INSURANCE COMPANY AND/OR MEDICARE FOR MEDICAL SERVICES RENDERED. I ALSO UNDERSTAND THAT I AM RESPONSIBLE FOR ANY BALANCES NOT COVERED BY MY INSURANCE BENEFITS.

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Patient Signature **Date**