Patient Information

NEW YORK CITY

EAR, NOSE, & THROAT CENTER

CHARLES P. KIMMELMAN, M.D. F.A.C.S.

Name ______________________________ Birth Date __________ SS # __________

Last First Middle I.

Address ____

No. Street Apt.No. City State Zip

Home Phone __________ Cell Phone __________ Gender __________

Responsible Party __________ Address __________

Relationship __________ Telephone __________

Occupation __________ Emergency Contact __________

Employer __________ Relationship __________

Work Address __________ Phone __________

Work Phone __________

Referring Doctor __________ Specialty __________

Address __________

Name of other referral source __________

Primary Medical Insurance

Company __________

Policy No. __________

Group No. __________

Address __________

Insured's Name __________

Relationship __________

Secondary Medical Insurance

Company __________

Policy No. __________

Group No. __________

Address __________

Insured's Name __________

Relationship __________

Assignment of Benefits and Acknowledgment of Receipt of Privacy Notice

I authorize payment of medical benefits to Charles P. Kimmelman, M.D. for medical related services. I accept full responsibility for the total amount of my bill. I also acknowledge that I have received a copy of the office's Notice of Privacy Practices.

Signed ______________________________ Date __________

Patient or legally authorized individual signature

Medicare Release

I authorize any holder of medical or other information about me to release to the Social Security Administration or their intermediaries or carriers, or to the billing agent of this physician, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

Signed ______________________________ Date __________

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