# Patient Intake Form

141 Little East Neck Road
West Babylon, NY 11704
T: (631) 321-1045
F: (631) 321-1102

Dr. Polcino
dr-polcino.com

Today's Date: Have you been to Dr. Polcino's in the last 3 years? ◯ Yes ◯ No

## PATIENT INFORMATION

First Name: Last Name:

Address: City: Zip:

Email:

Date of Birth: Marital Status: ◯ S ◯ M ◯ W ◯ D

Home phone #: Cell #:

## EMPLOYER INFORMATION

Employer Name: Work #:

## PHYSICIAN INFORMATION

Primary Care Physician: Physician Phone #:

Physician Address: City: Zip:

## PHARMACY INFORMATION

Pharmacy Name: Pharmacy Phone #:

Address: City: Zip:

## MEDICAL INSURANCE INFORMATION

Name of Policy Holder: Relationship:

Policy Holder's Employer:

Date of Birth of Insured (leave blank if patient is policy holder):

Insurance Company:

Policy #: Group:

Do you have secondary insurance? ◯ Yes ◯ No

I, the undersigned, have insurance with and assign directly to Dr. Michael H. Polcino all medicalbenefits, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits, and authorize the use of this signature on all of my submissions. **I am aware that I will be responsible for any laboratory or radiological charges not covered by my insurance company.**

Patient's Signature: Date: