

RHEUMATOLOGY ASSOCIATES

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PATIENT INFORMATION

PLEASE PRINT

DATE: _____

NAME OF PATIENT: _____ PHONE NUMBER: _____

STREET: _____

CITY: _____ STATE: _____ ZIP CODE: _____

AGE: _____ DATE OF BIRTH: _____ M/F: _____ SOCIAL SECURITY #: _____

YOUR OCCUPATION: _____

EMPLOYER: _____ WORK PHONE # _____

STREET: _____ CITY: _____ STATE: _____ ZIP CODE: _____

MARITAL STATUS: CIRCLE ONE:
S M W D IF MARRIED, SPOUSE'S NAME: _____ SS #: _____

OCCUPATION: _____ EMPLOYER: _____

WORK PHONE #: _____ STREET: _____ CITY: _____ STATE: _____ ZIP: _____

IN CASE OF EMERGENCY NAME OF NEAREST RELATIVE: _____ RELATIONSHIP: _____

STREET: _____ HOME PHONE #: _____

CITY: _____ STATE: _____ ZIP CODE: _____

TYPE OF MEDICAL COVERAGE: _____ POLICY NO: _____

OTHER COVERAGE: NAME OF PERSON INS. IS UNDER: _____

NAME OF COMPANY: _____ POLICY #: _____

NAME OF FAMILY PHYSICIAN: _____

STREET: _____ PHONE #: _____

CITY: _____ STATE: _____ ZIP CODE: _____

REFERRED BY: _____

**IT IS NOT THE POLICY OF THIS OFFICE TO MAIL STATEMENTS.
PAYMENT IS EXPECTED ON THE DAY OF TREATMENT. THANK YOU.**

Patient's signature or responsible party.

Patients who carry Health Care Insurance should remember that professional services are rendered and charged to the Patient and not to the Insurance Company. If the insurance company does not reimburse this office, it is the responsibility of the patient to take care of any unpaid claim. This office cannot accept responsibility for the negotiating of a settlement on a disputed claim. If you have any questions, we will, of course; assist you. Thank you.