PATIENT HEALTH SUMMARY

Noah Zinkin MD

775 Park Ave. Suite 225
Huntington, NY11743-7532

Dear valued patient,

Kindly fill out the form below and return it to us prior to your visit.

email: drzinkin@gmail.com
fax: (631) 923-1419
mail: Noah Zinkin, MD, 775 Park Avenue, Suite 225, Huntington, NY 11743

PATIENT INFORMATION:	
NAME:	
ADDRESS:	
CITY:	**STATE/ZIP:**
HOME PHONE:	**WORK PHONE:**
CELL PHONE:	**EMAIL:**
DOB:	**SS#:**
Referring physician(s):	
Primary Care Physician:	
INSURANCE:	
Insurance name:	
Policy number:	
Group number:	
Policy Holder Name/DOB:	
REASON FOR VISIT:	
CURRENT MEDICATIONS:	
ALLERGIES:	
□ **No known drug allergies** □ **Drug Allergies:**	

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NAME:
MEDICAL HISTORY:
Weight: _____ **Height: _____**
SURGICAL HISTORY:
FAMILY HISTORY:
TOBACCO/ALCOHOL HISTORY:
□ **Never smoked** □ **Currently smoke: ______pack(s)/day.** □ **Quit smoking: _____years ago** □ **Non-drinker** □**Rare** □ **Frequently: ____ drinks/day** □**Socially:_____ drinks/week**

Additional Information:

____

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____

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____

PHONE: (631)923-1420 / FAX: (631)923-1419

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PATIENT ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Patient Name: ______________________________

We have given the above-named patient a copy of our Notice of Privacy Practices. We have answered any questions that they have regarding this form.

Please list any individuals that you would like to have access to your medical records.

Signature of Patient:______________________________ Date: ________________

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PERMANENT SIGNATURE AUTHORIZATION

Patient Name: ________________________________

Insurance: ____________________________________

Policy Number: _________________________________

Policy Holder: __________________________________

Group Number: _________________________________

☐ I request that payment of authorized benefits be made to Noah Zinkin, MD

☐ I authorize the release of medical information to my insurance carrier and it's agents as required to process claims for benefits on my behalf.

☐ I acknowledge that if I am seen without necessary insurance referrals/authorizations, I will be responsible for any balance not covered by my insurance carrier. I understand that if my insurance coverage changes, it is necessary to notify Dr. Zinkin's office prior to my appointment.
I acknowledge that all copayments are payable at the time of my visit. If the copayment is not paid at time of visit, a $15.00 fee will be charged. If full payment is not received within 30 days, an additional $15.00 fee will be charged. All balances other than copayments will be billed ONE time. If payment is not received within one month, a fee of $15.00 will be charged monthly. If there are special circumstances, contact our Billing Department.

Patient Signature: ______________________________ Date: __________________

Parent Signature (if minor):______________________ Date: __________________

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