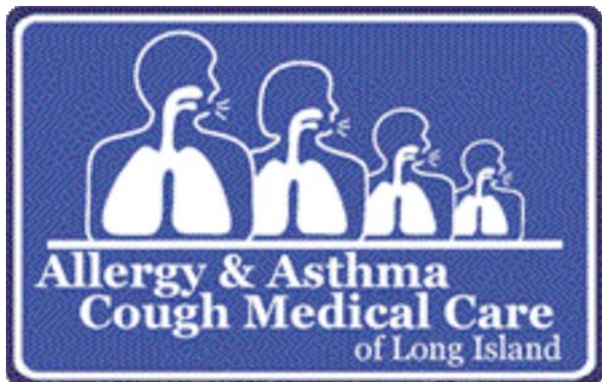

Stanley Goldstein MD
Desirie Zorn PNP
Maureen Reese PA-C

ACKNOWLEDGEMENT

I, ______________________________ (patient), acknowledge that I have been told about the copy of Allergy & Asthma Care of L.I.'s (the practice's) Notice Regarding Privacy of Personal Health Information. A copy will be furnished upon request.

______________________ ______________________

Date Signature of Patient or Guardian

____

Relationship to Patient

WELCOME TO ALLERGY & ASTHMA CARE OF LONG ISLAND

PATIENT INFORMATION (CONFIDENTIAL)

Name ____ Date Of Birth __________ Sex: M F
Last First

Address ________________________________ City _______________________ State ______ Zip ______

Home Phone ( ) ____________________________ *Cell Phone ( ) __________________________

E-mail Address ____

Social Security Number ___________________ Marital Status (Please circle) Single Married Divorced Widowed

Employer ____ Employer Phone ( ) __________________

Employer Address __________________________ City ____________________ State ______ Zip ________

Emergency Contact __________________________________ Emergency Contact Phone ( ) _____________

Primary Care Physician ___________________

Address _________________________________ City ________________________ State _____ Zip ______

Primary Care Dr. Phone ( ) __________________________ **Would You Like A Report Sent?** Y N

Referring Doctor Name (If different from Primary Physician) ____

Referring Doctor Address ____

Referring Doctor Phone ( ) ___________________________ **Would You Like A Report Sent?** Y N

PRIMARY INSURANCE INFORMATION *(Policy Holder of Insurance)*

Name of Insured ______________________________________ Sex: M F Date Of Birth __________

Social Security # _____________________________ Relationship to Patient __________________________

Address ______________________________ City ______________________ State _______ Zip _______

Employer ____ Employer Phone Number ( ) ______________

Employer Address ________________________ City ____________________ State _______ Zip ________

PRIMARY INSURANCE INFORMATION

Insurance Company _______________________________ Policy/ID# ___________________ Group# _____

Insurance Company Address __________________________ City/State/Zip ___________________________

Insurance Company Phone ( ) ___________________________ **Referral Required**? Y N

Specialist Copay amount $ _______________ Deductible amount $ ____________________

DO YOU HAVE ANY ADDITIONAL INSURANCE? YES NO
IF YES COMPLETE THE FOLLOWING:

Name of Insured ____ Sex: M F Date Of Birth _______

Social Security # ______________________________ Relationship to Patient ________________________

Address ______________________________ City ______________________ State _______ Zip _______

Insurance Company _______________________________ Policy/ID# ___________________ Group# _____

Insurance Company Address __________________________ City/State/Zip ____________________________

Insurance Company Phone ( ) ___________________________ **Referral Required**? Y N

Specialist Copay amount $ _______________ Deductible amount $ ______________

WHO MAY WE DISCUSS YOUR MEDICAL CARE WITH?

Name ____ Relationship to Patient __________________

ASSIGNMENT OF BENEFITS: I assign all Medical benefits to which I am entitled including Major medical, Medicare, private insurance, and any other health plans to Allergy & Asthma Care of Long Island PC. Photocopy of this assignment is to be considered valid as an original. I understand I am financially responsible for all charges not paid by my insurance. I understand it is Allergy & Asthma Care's policy that charges for all office visits to be paid at the conclusion of each visit. **I will be responsible to know my own insurance with regard to referrals, the number of visits that have been authorized by my primary care physician and when my referral expires. If I am seen in Allergy & Asthma Care without a valid referral, I will be financially responsible for the full amount of the services rendered.** I hereby authorize Allergy & Asthma Care of Long Island, PC to use my signature for insurance purposes and to release all information necessary to secure payment.

Signature ____ Date ______________________________

ALLERGY & ASTHMA CARE OF LONG ISLAND, P.C.

ISLAND MEDICAL RESEARCH, P.C.

Stanley Goldstein, MD
Desirie M. Zorn, CPNP
Maureen Reese PA-C

242 Merrick Road, Suite 401
Rockville Centre, NY 11570
_(516) 536 – 7336_
FAX: (516) 536 – 7650

Dear Patient,

It is with much pleasure that we welcome you to our office.

We evaluate and treat your conditions with the most up-to-date technology and medications. Being involved in asthma and allergy clinical research programs, has allowed us to be on the cutting edge of asthma and allergy diagnosis and treatment.

We like to give our patients first opportunity to participate in these programs before we offer this opportunity to the community.

Different programs arise continually. If you are interested in obtaining further information ***for yourself, family member or friend***, please sign below. Your signature allows us to contact you to provide you with information on these programs. ***There is NO commitment for just signing this form; this just allows us to contact you so you are able to receive information.***

There is NO cost to you, or your insurance company; in fact, we pay you for your time and travel, when participating.

Thank you for allowing us to give you this opportunity.

_____ *Yes, I am interested in hearing more about this opportunity.*

_____ *No, please do not contact me regarding this opportunity.*

Signature of Patient or Guardian: ____________________ *Date:* ________

Print ***Patient*** *Name:* ____________________________

Phone: ____________________________ *E-Mail:* ____________________
(Please circle your preferred method of contact)

Patient
Account # ____________________

(Revised March 2007)

Stanley Goldstein MD
Desirie Zorn PNP
Maureen Reese PA-C

PATIENT NAME: ___________________________

ACCOUNT # : _________________

RETAIL PHARMACY

NAME: ____

ADDRESS: ____

PHONE NUMBER: _________________________________

MAIL AWAY PHARMACY

NAME: ____

FOR OFFICE USE ONLY

INFORMATION ENTERED INTO COMPUTER ON _______________ BY ___________________