WELCOME TO THE OFFICE OF
STUART B. CHERNEY, M.D., P.C.
PRACTICE LIMITED TO ORTHOPAEDIC SURGERY

290 E. MAIN STREET, SUITE 700
SMITHTOWN, NEW YORK 11787
(631)361-7867

Today's Date: _______________________

Referred By: ________________________

PATIENT NAME: ____
AGE:______ BIRTHDATE:______________________ SS#: ___________________
HOME ADDRESS:____
CITY/TOWN:_______________________ STATE: ______________________ ZIP: ____________
PHONE #:__________________________ CELL PHONE #: ___________________________
PARENT OR PATIENT'S EMPLOYER:____
EMPLOYER'S ADDRESS:____
CITY/TOWN:____
STATE: ________________________ ZIP: _______________ PHONE #___________________

PRESENT COMPLAINT: ____
PARTICIPATING SPORT OR ACTIVITY: ______________________ SCHOOL:______________

PRIMARY INSURANCE CO:____
ADDRESS:____
CITY/TOWN:____
STATE:_______________________ ZIP:________________ PHONE #: ___________________
INSURED PARTY:_________________________ INSURED BIRTHDATE:__________________
SS#:________________________ POLICY #:__________________ ID#: __________________

SECONDARY INSURANCE CO.:____
ADDRESS:____
CITY/TOWN:____
STATE:_______________________ ZIP:_______________ PHONE #: ____________________
INSURED PARTY:___________________________ INSURED BIRTHDATE::________________
SS#:_________________________ POLICY #:_____________________ ID #:_____________

SCHOOL INSURANCE CO:____
ADDRESS:____
CITY/TOWN:_____________________________STATE:_____________ ZIP:________________
POLICY #: ____

PLEASE READ : ALL CHARGES ARE DUE AT THE TIME OF SERVICE. IF SURGERY IS INDICATED, THE PATIENT IS RESPONSIBLE FOR FURNISHING INSURANCE CLAIM FORMS TO THE OFFICE PRIOR TO SURGERY. ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO EXPEDITE INSURANCE CARRIER PAYMENTS. THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I HEREBY AUTHORIZE STUART B. CHERNEY, M.D. TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO THE PHYSICIAN ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

SIGNATURE:____ DATE:________________