BOYCE THOMPSON CENTER
1088 North Broadway
Yonkers, NY 10701

ST. JOHN'S MEDICAL GROUP

DOBBS FERRY PAVILION
128 Ashford Avenue
Dobbs Ferry, NY 10522

Name:_____ D.O.B:_____

Address:_____ Apt#____ City:_____ State:____ Zip Code:_____

SS#:_____ Sex: □M □F Marital Status: □M □S □D □W

Home Phone: (___)_____-_____ Cell: (___)_____-_____ Work: (___)_____-_____

E-Mail:_____

Pharmacy Name: _____ **Tel #**: _____

Emergency Contact:

Name:_____ Phone: (___)___-_____ Relationship:_____

INSURANCE INFORMATION:

Primary Insurance:_____ Policy #:_____

Name of Policyholder:_____ Relationship:_____

Secondary Insurance:_____ Policy#: _____

Name of Policyholder:_____ Relationship:_____

Assignment and release of Information:

I, the undersigned, certify that I (or my dependent) have insurance coverage as mentioned, and direct to St. John's Medical Group all insurance benefits, if any, otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges whether or not paid by the insurance. I hereby authorize the doctor to release all information necessary to secure payment of the benefits. Also, I authorize use of this signature on all insurance submissions.

SIGNATURE:_____ Date:_____