Jared F. Brandoff, M.D.
Paul Fragner, M.D.
Dov Kolker, M.D.
Daniel Markowicz, M.D.
Michael Schwartz, M.D.
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WP HOSPITAL physician associates

Orthopaedic Specialists
222 Westchester Avenue
West Harrison, NY 10604
914.946.1010

Patient Demographics

Patient's Last Name _____ First Name _____ Middle Initial _____

SSN _____ Date of Birth _____ Age _____ Gender F M

Address _____ Apt. # _____ City _____ State _____ Zip _____

Race:
☐ American Indian/Alaska Native ☐ Asian ☐ White
☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ Decline to Answer

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Decline to Answer Preferred Language: _____

Marital Status: ☐ Single ☐Married ☐ Divorced ☐Widowed ☐Separated Student Status ☐FT ☐PT

Home Phone _____ Day Phone _____

Email Address _____ Cell Phone _____

Employer _____ Occupation _____ ☐Retired?

Employer Address _____

Emergency Contact _____/_____ Phone _____
Name Relationship

Primary Care Physician Name: _____ Phone:_____

Referring Physician Name: _____ Phone: _____

Pharmacy Name: _____ Phone: _____

Pharmacy Address: _____

Primary Insurance Coverage: _____

Policy Holder Name: _____ SSN:_____ DOB:_____

Secondary Insurance Coverage: _____

Policy Holder Name: _____ SSN: _____ DOB: _____

This visit is covered by: ☐ No Fault Insurance ☐ Workers' Compensation _____

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information. I authorize the release of any medical information necessary to process an insurance claim and request that payment of benefits be made to the physician unless my account has been paid in full.

Responsible Party Signature _____ Date_____

Responsible Party Name _____ Relationship _____

Patient History Form

Name: _____ **Date of Birth:** _____

Reason for Visit:

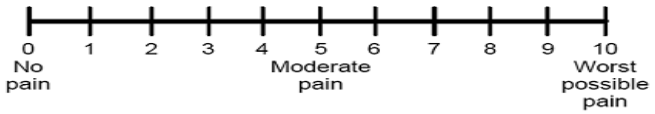
_____

_____

Please List All Current Medications			☐ **Not Currently Taking Any Medications**		
Medication Name	**Dosage**	**How Often Taking**	**Medication Name**	**Dosage**	**How Often Taking**
Vitamins/ Supplements	**Dosage**	**How Often Taking**	**Vitamins/ Supplements**		**How Often Taking**

Allergies (e.g. medication, latex, egg)		☐ **No Known Allergies**	
Allergen	Type of Reaction	Allergen	Type of Reaction

Please indicate (circle) your current pain scale in relation to your current condition:



How would you prefer that we contact you?

☐ Home Phone ☐ Cell Phone ☐ Work/Day Phone ☐ Patient Portal ☐ Home Address

☐ Other _____

Patient Signature: _____ Date: _____

Patient Representative Signature:_____ Relationship: _____

White Plains Hospital
Exceptional, every day.

UNIFORM ASSIGNMENT AND RELEASE OF INFORMATION STATEMENTS

Authorization for release of information by

WHITE PLAINS HOSPITAL

I hereby authorize and direct the above named Medical facility, having treated me, to release to governmental agencies, insurance carriers, or others who are financially liable for my hospitalization and medical care, all information needed to substantiate payment for such hospitalization and medical care and to permit representatives thereof to examine and make copies of all records relating to such care and treatment.

_____
Signature of Patient or Authorized Representative

I hereby assign, transfer and set over to the above named Medical facility sufficient monies and/or benefits to which I may be entitled form governmental agencies, insurances carriers, or others who are financially liable for my hospitalization and medical care to cover the costs of the care and treatment rendered to myself or my dependent in said hospital or medical facility.

_____
Signature of Patient or Authorized Representative

I, _____, give consent and authorize the hospital and its employees, and the hospital agents or contracted parties (including debt collection agencies) to contact me and use an automated telephone dialing system to call my cellular or mobile phone number regarding all matters relating to the services and care provided, including payment.

_____
Signature of Patient or Authorized Representative

FOR PATIENTS ENTITLED TO MEDICARE BENEFITS

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

_____
Signature of Patient or Authorized Representative

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DISCLOSURE AUTHORIZATION

PATIENT NAME (print) : _____ DATE OF BIRTH: _____

I authorize White Plains Physician Associates to disclose the following to the individual(s) listed below:

( ) Speak to provider on my behalf

( ) Pick up / discuss labs, notes or prescriptions, etc. from office

( ) Other _____

( ) All of the above

Restrictions (if any):

Name: _____ Expiration Date: _____

Name: _____ Expiration Date: _____

Name: _____ Expiration Date: _____

_____ _____

Patient Signature Date