RHEUMATOLOGY CONSULTANTS OF WNY, P.C.

PLEASE PRINT

PATIENT NAME:_____**DOB:**____/____/____

STREET ADDRESS:_____**APT#**_____

CITY:_____**STATE:**_____**ZIP**_____

HOME PHONE: ( )_____**CELL: ( )**_____**WORK: ( )**_____

PREFERRED NUMBER TO CONTACT YOU: ___CELL ___HOME ___WORK

SS#_____**EMAIL:**_____

EMPLOYER :_____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY:_____

SUBSCRIBER NAME:_____ **SUBSCRIBER DOB:**_____

RELATIONSHIP TO PATIENT:_____**SUBSCRIBER SS#**_____

INSURANCE ID#_____**GROUP #**_____

SUBSCRIBER EMPLOYER_____

SECONDARY INSURANCE:_____

SECONDARY INSURANCE ID#_____**GROUP#**_____

SUBSCRIBER NAME:_____**SUBSCRIBER DOB:**_____

FAMILY MD:_____ **ADDRESS**_____

REFERRING MD:_____**ADDRESS** _____

PHARMACY NAME_____**ADDRESS**_____

CITY:_____**STATE:**_____**PHARMACY PHONE#**_____

**FEDERAL REGULATIONS IN REGARD TO HEALTH INSURANCE REQUIRE THE FOLLOWING INFORMATION BE INCLUDED IN YOUR HEALTH RECORDS:*

***PRIMARY LANGUAGE:**	***RACE:**	**ETHNICITY:**
___ENGLISH	**___CAUCASIAN**	**___HISPANIC OR LATINO**
___SPANISH	**___AFRICAN AMERICAN**	**___NONHISPANIC OR LATIN**
	___HISPANIC	
___OTHER_____	**___OTHER**_____	

Sign Name:_____**Date:**_____

RHEUMATOLOGY CONSULTANTS OF WNY, PC

PATIENT NAME_____DATE_____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

MEDICATION NAME DOSE DIRECTIONS

_____

_____

_____

_____

_____

_____

_____

_____

_____

Allergies to Medications

Name Reaction

_____

_____

_____

Names and addresses of doctors you presently see:

_____

_____

_____

_____

Please use other side if necessary