RHEUMATOLOGY CONSULTANTS OF WNY, P.C.
NEW PATIENT INFORMATION
PLEASE PRINT

PATIENT NAME:____ **TODAY'S DATE:**_______________________

ADDRESS:_____________________________________**CITY:**______________**STATE:**_____**ZIP:**__________________

HOME PHONE: (   )_____________________**CELL: (   )**_____________________**WORK: (   )**__________________

SS#_____________________________ **DOB:**_________________**EMAIL:**_____________________________________

EMPLOYER NAME:____

EMPLOYER ADDRESS:____

INSURANCE INFORMATION

INSURED (RESPONSIBLE PARTY) NAME:____

RELATIONSHIP TO PATIENT:____

PRIMARY INSURANCE:____

INSURANCE ID#____**GROUP #**_____________________________

SECONDARY INSURANCE:____

SECONDARY INSURANCE ID#____

FAMILY MD:____________________________________ **ADDRESS**____

REFERRING MD:__________________________**ADDRESS** ____

PHARMACY NAME__________________________________**ADDRESS**___________________________________

CITY:____________________________**STATE:**__________**PHARMACY PHONE#**_____________________________

EMERGENCY CONTACT NAME:_____________________________________**PHONE #**___________________________

RELATIONSHIP TO YOU:____

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

***PRIMARY LANGUAGE:**

___ENGLISH ___SPANISH
___FRENCH ___GERMAN
___ITALIAN ___VIETNAMESE
___OTHER

***RACE:**

___CAUCASIAN ___HISPANIC ___ALASKA NATIVE
___AFRICAN AMERICAN ___PAC ISLANDER ___CHINESE
___ASIAN ___AMERICAN INDIAN ___JAPANESE
___FILIPINO ____MULTI-RACIAL ___NATIVE HAWAIIAN

****ETHNICITY: ___HISPANIC OR LATINO ___NONHISPANIC OR LATINO***

SIGN NAME:____**DATE:**______________________

Rheumatology Consultants of WNY, P.C.

Patient Name:______________________________Date:_________________

Please list all medications that you are currently taking:

Medication	Dose	Frequency

Allergies to Medications:

Name and Address of Doctors Your Presently See: