

SUFFOLK BEHAVIORAL MEDICINE P.C.

MULCHAND CHUGH, M.D.

**535 Broad Hollow Road
Suite # B-12, Melville, NY – 11747**

DATE: _____

PATIENT'S NAME _____ DATE OF BIRTH _____

SEX _____ SOCIAL SECURITY NUMBER (SSN) _____

HOME ADDRESS _____

CITY _____ STATE: _____ ZIP CODE _____

HOME PHONE _____ WORK/CELL PHONE _____

NEXT OF KIN(IN CASE OF EMERGENCY) _____

CONTACT INFO FOR NEXT OF KIN _____

PHONE NUMBER OF NEXT OF KIN _____

REFERRED BY _____

PRIMARY INSURANCE INFORMATION

Insurance Company Name: _____ Policy Holder's ID Number: _____

Policy Holder Name: _____ Policy Holder SSN _____

Policy Holder DOB: _____ Policy Holder's Tel Number _____

Policy Holder address _____ City _____ Zip _____

Policy Holder Employment Information _____

SECONDARY INSURANCE INFORMATION

Secondary Insurance Company Name: _____ Policy Holder's ID Number: _____

Policy Holder Name: _____ Policy Holder's Tel Number _____

Policy's Holder's DOB: _____ Policy's Holder's Relation to Patient: _____

Policy Holder address _____ City _____ Zip _____

CURRENT MEDICATIONS IF ANY _____

MEDICAL PROBLEMS _____

PHARMACY-NAME/ADDRESS/PHONE NUMBER _____

SCHOOL INFORMATION IF ANY _____

I agree for treatment and will be responsible for all financial terms of my treatment and I allow Suffolk Behavioral Medicine P.C. and Dr. Mulchand Chugh to contact my insurance on my behalf to verify benefits and seek information as needed during the process of this treatment as per HIPPA law's.

Patient's OR Parents Signature: _____