Refuah

For Refuah Office Use: Medical Record #:_____ Date: _____/_____/_____

Last Name: _____ **First Name**: _____

Patient Mother's Maiden Name: _____ **First Name**:

_____

Address: _____ **Apt#**: _____

City: _____ **State**: _____ **Zip**: _____

Email Address: _____ **Web Enable □Yes □No**

Home Phone # :(____) _____ **Cell #** :(____) _____

Birth Date: _____/_____/_____ □ **Male** □ **Female**

Primary language spoken: _____

In case of emergency, contact (other than patient):_____

Home Phone #: (_____) _____ **Cell #**: (_____) _____

Relationship to patient: _____

Race: □ White □ Black or African-American □ Asian □ American Indian or Alaskan □ Native Hawaiian or Other Pacific Islander □ Refuse to Report

Ethnicity: □ Hispanic or Latin □ Not Hispanic or Latin □ Unknown

Diversity (Check all that apply):

_____Handicapped _____Visually Impaired _____Hearing Impaired _____Cognitively Impaired

Employment Status:

_____ Employed full-time. Employer's Name _____

_____ Employed part-time. Employer's Name _____

_____ Not Employed

728 North Main Street
5 Twin Avenue
Spring Valley, NY 10977
100 Rt 59-Suite 105
Suffern, NY 10901
Tel: 845 354 9300
Fax: 845 354 3305
refuahhealthcenter.com

Refuah

_____ Self Employed

_____ Retired

_____ On active military duty

_____ Reserved for national assignment

_____ Veteran

Migrant Worker: _____ Not a Farm Worker _____ Migrant _____Seasonal

Responsible Party/Parties:

Name of person(s) responsible for this account:

_____ _____

Home Phone #: (_____) _____ **Cell #**: (_____) _____

Address: _____

Relationship(s) to patient: _____

_____

Pharmacy Name and Address: _____

Insurance Information:

_____I am insured (please provide a copy of your insurance card to Refuah)

Primary Insurance Name: _____ **ID#**_____

Insurance Address: _____

Secondary Insurance Name: _____ **ID#**_____

Insurance Address: _____

____ I am not insured and would like to make payments by using the Sliding Fee Scale Program.

Authorization:
By signing this form, I attest that all of the information above is accurate and true to the best of my knowledge and belief.

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X_____ X_____
Signature of patient or legally authorized representative Date

X_____ X_____
Signature of Witness Date

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