PHILIP RABITO, M.D., F.A.C.E.
150 East 77th Street Office 1D
New York, NY 10075
(877) 703-3775

Date: ______________

Name:____

Date of Birth: ____________________ Social Security #: ____________________

Home Phone #: ____________________ Business Phone #: ____________________

Cell Phone #: ____________________ Email: ____________________

Home Address: ______________________________ Apt: __________

City: ____________________ State: ______________ Zip Code: ____________

Marital Status: ____________________ Sex: ____________

Primary Physician: ____________________ Phone #: ____________________

Referred by: ____

List All Prior Surgery: ____

____

____

Serious Past Illnesses: ____

____

____

Drug Allergies & Reactions: ____

Food Allergies: ____

Current Medication/ Vitamins/ Herbs: ____

____

Pharmacy: ____________________ Phone #: ____________________

Spouse Name: ____________________ Phone #: ____________________

Spouse Date of Birth: ____________________ Spouse Social Security #: ____________________

Emergency Contact: ____________________ Relationship: ____________________

Phone #: ____________________

INSURANCE INFORMATION

Please provide the following information:

PRIMARY:

Insurance Company____

Insurance Address: ____

City: ______________________ State: __________ Zip Code: __________

Insurance ID #: ______________________ Group #: ______________________

Policy Holder: ______________________ Social Security #: ______________________

Relationship: ______________________ Date of Birth: ______________________

SECONDARY:

Insurance Company: ____

Insurance Address: ____

City: ______________________ State: __________ Zip Code: __________

Insurance ID #: ______________________ Group #: ______________________

Policy Holder: ______________________ Social Security #: ______________________

Relationship: ______________________ Date of Birth: ______________________

Payment Terms:

Payment is requested at the time services are rendered. I fully understand and accept these terms.

Patient's Signature: ______________________________ Date: ______________

PHILIP RABITO, M.D.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Philip Rabito, M.D. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to the attached Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy prior to signing the consent. Philip Rabito, M.D. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Philip Rabito, M.D. at 150 East 77th Street, New York, NY 10075

With my consent, Philip Rabito, M.D. may mail to my home or other designated location any items that assist the practice in carrying out (TPO) such as appointment reminder cards and patient statements as long as they are marked Personal Confidential.

With my consent, Philip Rabito, M.D. may e-mail to my home or other designated location any items that assist the practice in carrying out (TPO), such as appointment reminder cards and patient statement. I have the right to request that the office of Philip Rabito, M.D. restricts how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my restrictions, but if it does it is bound by this agreement.

By signing this form, I am consenting Philip Rabito, M.D. to use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Philip Rabito, M.D. may decline to provide treatment to me.

____

Signature / Date

____

Patient’s Name

____

Print Name or Patient or Guardian

PHILIP RABITO, M.D.
150 East 77th Street ◇ New York, NY 10075
Tel (877) 703-3775

MEDICAL RECORDS RELEASE AUTHORIZATION

Please complete the following information:

Patient name:____DOB: ____________________________

Address: ____

City: ____State: _______________ Zip Code: __________________

Phone: ___________________________________

I, ___________________________, authorize the release of the following records (please select):

___ Office Notes ___ Laboratory/ Pathology Records

___ Billing Records ___ Other (specify)

These records are for services provided on the following dates: From: (Year) _____ to (year) _____

Please send records to:

Name: ____

Address: ____

City: __________________________ State: __________Zip Code: ________

Phone: _________________________Fax: ________________________

Patient's Signature: ____ **Date:** ____________________