Dr. Daniel Cameron and Associates

Daniel J. Cameron, M.D., M.P.H., P.C.

657 Main Street, Mt. Kisco, NY 10549

Phone: 914-666-4665 Fax: 914-666-6271

DATE: _____

PATIENT INFORMATION						
Patient's Last Name	Patient's First Name					Home Phone No.
Street Address	City		State		Zip Code	Social Security No.
Occupation (Indicate if student)	M	F	Date of Birth	Age	Marital Status	Spouse's Name (If applicable)
Patient's Employer/School Name	Cell Phone No.					Work Phone No.
Employer Address	City			State		Zip Code

OTHER INFORMATION			
Emergency Contact	Relationship		Phone No.
Referred By:	County you live in		How long did it take you to get here?

INSURANCE INFORMATION			
Primary Insurance Company	Name of Policy Holder (If not self)		
Primary Insurance ID #	Group #	Policy Holder's DOB	Co-pay Amount
Social Security # of Policy Holder	Relation to Policy Holder	Is your primary insurance through an employer? Yes / No Employer's Name:	

OTHER INSURANCE INFORMATION			
Secondary Insurance Company	Name of Policy Holder (If not self)		
Secondary Insurance ID #	Group #	Policy Holder's DOB	Co – pay amount
Social Security # of Policy Holder	Relation to policy holder	Is your primary insurance through an employer? Yes / No Employer's Name:	

I authorized the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original. I certify that the information I have reported above is truthful to the best of my knowledge. **I understand that if the insurance information I have provided is incorrect or not in effect for the date of service, that I will be responsible for all charges incurred.** I understand that I am responsible for the terms and conditions of my individual insurance plan. Due to the vast number of different insurance policies, I realize that Dr. Daniel Cameron and Associates/FMA personnel are not responsible for informing me which test and procedures are covered. I herby give consent to medical examination and treatment for the above patient.

_____ _____ _____

Signature Of Patient Responsible Party (***MUST BE OVER 18***) Relation (Example: Self, Spouse, Parent) Date: