Stony Brook Medicine

Patient Name: ____ MRN: _______________

Group #: ________________ Date: _______________

CLINICAL PRACTICE MANAGEMENT PLAN

Patient Name: ____

Last First Middle

RELEASE OF INFORMATION

Last I hereby authorize and direct ____, University Faculty Practice corporations having treated me, to release to governmental agencies, insurance carriers, or others who are financially liable for my medical care, all information needed to substantiate payment for such medical care and to permit representatives thereof to examine and make copies of all records relating to such care and treatment.

X ____ Date: _______________

Signature of Patient or Authorized Representative

UNIFORM ASSIGNMENT

I hereby assign, transfer and set over to ____, University Faculty Practice Corporations sufficient monies and/or benefits to which I may be entitled from governmental agencies, insurance carriers, or others who are financially liable for my medical care, to cover the cost of care and treatment rendered to myself or my dependent.

In addition, I also assign, transfer and set over to all of the other University Faculty Practice Corporations from which I may require medical care, sufficient monies and/or benefits to which I may be entitled. These other University Faculty Practice Corporations are as follows: Stony Brook Anesthesiology, Stony Brook Dermatology, Stony Brook Family Medical Group, Stony Brook Internists, New York Spine and Brain Surgery, Neurology Associates of Stony Brook, University Associates of Obstetrics and Gynecology, Stony Brook Preventative Medicine Services, Stony Brook Ophthalmology, Stony Brook Orthopedic Associates, Stony Brook Children's Services, Stony Brook Psychiatric Associates, Stony Brook Radiation Oncology, Stony Brook Radiology, Stony Brook Surgical Associates, and Stony Brook Urology.

X ____ Date: _______________

Signature of Patient or Authorized Representative

Account Representative: ________________________________

MRN: _______________ Date Updated: _______________

Updated / Demographic Information

Patient Name: ______________________
Address: ______________________
City: ______________________
State: ______________________
Zip Code: ______________________
Telephone #: ______________________
Daytime Telephone #: ______________________
Social Security #: ______________________
Date of Birth: ______________________

Responsible Party: ______________________
Address: ______________________
City: ______________________
State: ______________________
Zip Code: ______________________
Telephone #: ______________________
Daytime Telephone #: ______________________
Social Security #: ______________________
Date of Birth: ______________________

Medical Insurance Information

"Primary" Insurance

Company Name: ______________________
Address: ______________________
____
Telephone #: ______________________
Policy Holder: ______________________
Policy #: ______________________
Relationship to Patient: ______________________
Policy Holder's Date of Birth: ______________________
Policy Holder's Social Security #: ______________________
Employer Name: ______________________
Employer Address: ______________________
Effective Date of Coverage: ______________________
Primary Care Provider: ______________________
Telephone #: ______________________
Date of Birth: ______________________

"Secondary" Insurance

Company Name: ______________________
Address: ______________________
____
Telephone #: ______________________
Policy Holder: ______________________
Policy #: ______________________
Relationship to Patient: ______________________
Policy Holder's Date of Birth: ______________________
Policy Holder's Social Security #: ______________________
Employer Name: ______________________
Employer Address: ______________________
Effective Date of Coverage: ______________________
Primary Care Provider: ______________________
Telephone #: ______________________
Date of Birth: ______________________

No Fault

Policy Holder: ______________________
Policy #: ______________________
Date of Accident: ______________________
Claim/File Accident: ______________________
NF Insurance Name: ______________________
Insurance Address: ______________________
____
Insurance Carrier Telephone #: ______________________

Blue Shield and/or Blue Cross

Address: ______________________
Policy Holder: ______________________
Policy #: ______________________
Group #: ______________________

Worker's Compensation

Employer at the time of Accident: ______________________
Employer Name: ______________________
Employer Address: ______________________
____
Employer Telephone #: ______________________
Social Security #: ______________________
WC Insurance Name: ______________________
Insurance Address: ______________________
____
Date of Accident: ______________________
WCB #: ______________________
Carrier Claim: ______________________