NEW MILFORD MEDICAL GROUP

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PRIMARY CARE
Harold J. Kamm, MD
Jeffrey C. Tyler, MD
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CARDIOLOGY
Michael G. Levine, MD, FACC
William Cicio, MD, FACC
Donald I. Katz, MD, FACC

PHYSICIANS ASSISTANTS
Dimitri Ghecas, MBA, PA-C, PT
Amanda Novella, MS, PA-C

Patient's Name:_____
Last First Middle

Address:_____

City:_____ State:_____ Zip Code:_____

Primary Contact Phone:_____ Is this Home or Cell ? Marital Status (circle one): S M D W

Race (circle one): Caucasian/White African-American Asian Hispanic Indian Multiracial Other _____

Primary Language: English Spanish Other _____ Ethnicity: Hispanic/Latino Not Hispanic/Latino

Social Security No.:_____ Date of Birth: _____ Age:_____

Email Address:_____ Home/Cell Phone (secondary contact number):_____

Employer:_____ Work Phone:_____

Spouse's Name:_____
Last First Middle

Social Security No.:_____ Date of Birth: _____ Age:_____

Email Address:_____ Cell Phone:_____

Employer:_____ Work Phone:_____

Pharmacy 1st Choice _____ Location _____

Pharmacy 2nd Choice_____Location_____

If mail order pharmacy, Pharmacy ID number: _____

Person to notify in case of emergency:_____Relationship:_____

Home Phone Number: _____ Cell or Alternate Number:_____

INSURANCE INFORMATION

Primary Insurance:_____ Secondary Insurance:_____
Please give your insurance cards to the receptionist so we may keep a copy on file.

Policy Holder: Name:_____ Relationship to you: Self Spouse Child

Social Security No.:_____ Date of Birth:_____

Place of Employment:_____

I hereby authorize New Milford Medical Group to furnish all information to insurance carriers and other health care providers concerning my illness and treatments and assign all payments for medical services rendered to myself or my dependents to New Milford Medical Group, LLC. I understand that I am responsible for any amount not covered by insurance. This information includes Protected Health Information.

Signature:_____ Date: _____