

Joan and Sanford I. Weill  
Medical College

David J. Wolf, M.D., F.A.C.P.  
Clinical Associate Professor of Medicine  
Associate Attending Physician

Telephone: 212 688-7100  
Fax: 212 308-5242

115 E. 61st Street, 11th Floor  
New York, NY 10021

**HEALTH INSURANCE INFORMATION**

DATE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ SSN: \_\_\_\_\_

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_ E-MAIL: \_\_\_\_\_

WORK PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

WHO REFERRED YOU TO DR. WOLF?: \_\_\_\_\_

NEW YORK HOSPITAL HISTORY NUMBER: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

DO YOU HAVE MEDICARE?  YES  NO MEDICARE NO: \_\_\_\_\_

PRIMARY INSURANCE CARRIER NAME: \_\_\_\_\_

ID # \_\_\_\_\_ GROUP # \_\_\_\_\_

ARE YOU THE POLICY HOLDER?  YES  NO (If no, please complete the following two lines):

NAME OF POLICY HOLDER: \_\_\_\_\_ DOB: \_\_\_\_\_

RELATION TO POLICY HOLDER:  SPOUSE  CHILD  OTHER

SECONDARY INSURANCE CARRIER NAME: \_\_\_\_\_

ID # \_\_\_\_\_ GROUP # \_\_\_\_\_

ARE YOU THE POLICY HOLDER?  YES  NO (If no, please complete the following two lines):

NAME OF POLICY HOLDER: \_\_\_\_\_ DOB: \_\_\_\_\_

RELATION TO POLICY HOLDER:  SPOUSE  CHILD  OTHER

FOR ANY OUT-OF-POCKET CHANGES, I WISH TO PAY BY (circle one):

VISA  MASTERCARD  AMERICAN EXPRESS  CHECK  CASH

Payment is expected on the same day of service. The office will submit your claim for you as a courtesy.

I authorize payment of medical benefits to Dr. David Wolf. I am responsible for payment of all services rendered by Dr. David Wolf.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_