LEWIS J. KASS, MD
Westchester Pediatric Pulmonology and Sleep Medicine

NEW PATIENT INFORMATION FORM

Please fill out each section completely.

Insurance Cards Copied _____	Date:

Patient Name	Date of Birth	Sex
Address	City, State, Zip	Home Phone
Mother's Name, Work #, Cell #	Father's Name, Work #, Cell #	
Primary Email	Pharmacy name & number	

Referring Physician	Phone
Address	
Pediatrician	Phone
Address	
Other Involved Physician	Phone
Address	

Primary Insurance		Phone
Address		
Insured Person	Date of Birth	So. Sec. #
Policy/Certificate #	Group #	Eff. Date
Employer		Phone
Employer Address		
Secondary Insurance		Phone
Address		
Insured Person	Date of Birth	So. Sec. #
Policy/Certificate #	Group #	Eff. Date
Employer		Phone
Employer Address		

AUTHORIZATION TO RELEASE INFORMATION, ASSIGNMENT OF PAYMENTS TO PROVIDER:

I hereby authorize the release of any information acquired in the course of my treatment to appropriate medical personnel, and to my insurance carrier(s). I am aware that Dr. Kass does not participate with insurances in his office, and payment is expected in full at the time of visit.

_____ Insured or Authorized Person

_____ Date