Dale M. Abadir, M.D.
Michelle C. Abadir, M.D.

Cosmetic Surgery,
Cosmetic Dermatology
& Dermatologic Surgery

90 South Ridge Street
Rye Brook, NY 10573
914.937.5500 or 7562 tel
914.937.7678 fax
info@drabadir.com email
www.drabadir.com web

Abadir Associates

WHERE DEDICATED CARE + HIGH TECHNOLOGY MEET

PATIENT INFORMATION FORM

Patient's Name **DOB** ☐ **Male** ☐ **Female**

Home Address **City** **State** **Zip**

Home Telephone **Cell** **Email**

☐ **White** ☐ **Black/African-American** ☐ **Asian** **Ethnicity** **Language**

Referred by ☐ **Friend** ☐ **Internet/Google** ☐ **Physician** ☐ **Other**

Patient or Parent's Employer

Employer's Address **City** **State** **Zip**

Employer's Telephone

Pharmacy Name **Telephone**

Pharmacy Address **City** **State** **Zip**

Primary Insurance Company Name **Policy #**

Name of Insured if other than Patient

Relationship to Patient **Date of Birth**

Secondary Insurance Company Name **Policy #**

Name of Insured if other than Patient

Relationship to Patient **Date of Birth**

Contact In case of Emergency **Telephone**

Relationship

PLEASE READ: ALL CHARGES ARE DUE AT THE TIME OF SERVICE. THE PATIENT OR GUARANTOR IS RESPONSIBLE FOR FURNISHING INSURANCE CARDS TO THE OFFICE. ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO EXPEDITE INSURANCE CARRIER PAYMENTS. THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE. PATIENT'S COVERED UNDER AN HMO PLAN MUST BRING WITH THEM A COPY OF THE REFERRAL OR REFERRAL NUMBER.

INSURANCE AUTHORIZATION AND ASSIGNMENT
I HEREBY AUTHORIZE MY PROVIDER, DR ABADIR, TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS, AND I HEREBY ASSIGN TO THE PHYSICIAN ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS.
I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

Guarantor's Signature **Date**