Diabetes Wellness Education Services

Date:_____

Client Information

Last Name: _____ First Name: _____ MI: _____

Address: _____City:_____State:_____Zip:_____

Home Telephone: _____ Cell Phone Number: _____

Date of Birth: _____ Gender: M F

Insurance Information

PRIMARY INSURANCE CARRIER

Insurance Co. Name: _____ ID Number: _____

Address: _____
Street City State Zip

Telephone Number: _____ Relationship to Patient: _____

Policy Holder's Name: _____ Policy Holder's Date of Birth: _____

SECONDARY INSURANCE CARRIER

Insurance Co. Name: _____ ID Number: _____

Address: _____
Street City State Zip

Telephone Number: _____ Relationship to Patient: _____

Policy Holder's Name: _____ Policy Holder's Date of Birth: _____

Payment Information

Paid Amount _____ Check#_____ MC___ Visa___ Amex___

Card number: _____Exp date:_____Security code:_____

Name on card: _____ Billing Zip Code: _____

Cardholder signature: _____ Amount to be charged:_____

Long Island
Community Hospital

CLIENT CONFIDENTIALITY RELEASE STATEMENT

I authorize the staff of the Long Island Community Hospital Diabetes Wellness Education Services to leave information pertaining to my care by the following methods, and will assume responsibility to them whenever this information changes.

	YES	NO
Home telephone/Answering machine _____	_____	_____
Cell phone and voice mail _____	_____	_____
Work phone and voice mail _____	_____	_____
Email _____	_____	_____

PRINT NAME _____

SIGNATURE _____ DATE _____