Dwight D. Lewis MD
3125 Main Street
Buffalo New York 14214
716-834-1455

New Patient Information

PLEASE PRINT ALL INFORMATION

Previous Primary Care Provider_____

Patient's Name_____

D.O.B._____Age_____Gender M F Marital Status_____

Address_____City_____Zip_____

Home Phone_____Cell Phone_____Other Phone_____

Insurance Information

Primary Insurance_____Telephone_____

Address_____City_____Zip_____

Effective Date_____Group# _____ ID#_____

Claim Address_____City_____Zip_____

Subscriber (Person responsible for fees)_____

Relationship to insured: Self Spouse Child Other

Secondary Insurance (If applicable)_____Telephone_____

Address_____City_____Zip_____

Effective Date_____Group# _____ID#_____

Claim Address_____City_____Zip_____

Subscriber (Person responsible for fees)_____

(Any other insurance can be written on the back)

Relationship to insured: Self Spouse Child Other

Please Note: Co-payment and other charges (i.e. form filling payments, Self Pay if not insured) are designated as the patient's responsibility and are due at time of services. If the patient is more than 20 minutes late for his or her scheduled appointment, or does n't cancel their appointment within 24 hours, or do not show for his or her appointment, he or she will be charged a No Show fee of 35 dollars at the time of their next visit.

Notify in Case of Emergency (Please give two contacts outside of your home)

Name_____Relationship_____

Address_____City_____Zip_____

Home Phone_____ Work Phone_____

Nearest Relative (not living with you)_____

Relationship_____

Home Phone_____ Work Phone_____

I CONSENT TO DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR PURPOSE OF TREATMENT, PAYMENT AND/OR HEALTHCARE OPERATIONS. I ALSO CONSENT TO THE USE AND DISCLOSURE OF MY PROTECED HEALTH INFORMATION TO:

Name_____Relationship_____Phone_____

Name_____Relationship_____Phone_____

Name_____Relationship_____Phone_____

Any Limitations or Restrictions?

_ No

Yes:_____

_____

_____

(Please use back for more space)

Please read carefully:

I hereby authorize Dwight Lewis, MD Medical Practice to furnish information concerning the above patient's illness. I direct the insurer to pay, without equivocation, directly to the physicians, all benefits due he/she as a result of this claim. Although covered by insurance, I am personally responsible for all charges. A photocopy of this of this authorization will be valid as the original. This agreement will remain in effect until revoked by me in writing.

Financial Agreement: I hereby agree, whether signing as an agent or as a patient, that in consideration of the services to be rendered to the patient, I shall pay the account of the office in accordance with the rates and terms of the office provided for the services to be completed. Should the account be delinquent and thereby require the services of an attorney for collections, I shall pay a reasonable attorney's fee and collection expense.

Name of Patient/Representative (Print)_____

Signature_____ Date_____