Charles H. Thorne, MD, PLLC 812 Park Avenue, New York, NY 10021 (212) 794-0044
Website: charlesthornemd.com E-mail: charlesthorne@charlesthornemd.com

Name: ______________________________

Birth Date: ____________ Social Security #: ____________

Address: ______________________________

City, State, Zip: ______________________________

Employer: ______________________________

E-mail: ______________________________

Home Phone: ____________ Work Phone: ____________

Mobile Phone: ____________ Other: ____________

Age: ________ Height: ________ Weight: ________

Emergency Contact:

Name: ____________ Relationship: ____________

Home Phone: ____________ Work/Cell Phone: ____________

Who referred you?
Address: ______________________________

Reason for visit: ______________________________

May we mail medical information to the address provided? Yes No
May we mail promotional information to the address provided? Yes No

May we leave a message for you at home? Yes No

Medical History

Medications: ______________________________

Allergies: ______________________________

Medical Problems: ______________________________

Previous Surgery: ______________________________

Reactions to Anesthesia: ______________________________

Smoking: ______________________________

Pharmacy Name, Address & Tel. # ______________________________

Charles H. Thorne, MD, PLLC **812 Park Avenue, New York, NY 10021 (212) 794-0044**
Website: charlesthornemd.com **E-mail: charlesthorne@charlesthornemd.com**

Patient's Name: ____

Subscriber for the Primary Insurance:		*Subscriber for the Secondary Insurance:*	
Name:	____________________	*Name:*	____________________
SS#:	____________________	*SS#*	____________________
DOB:	____________________	*DOB:*	____________________
Relationship:	____________________	*Relationship:*	____________________
PRIMARY INS:	____________________	*SECONDARY INS:*	____________________
#:	____________________	*#:*	____________________

I authorize payment of all medical benefits to Charles H. Thorne, MD, ***PLLC*** *and understand that I am responsible for all remaining balances not covered by my insurance carriers. A copy of this signed authorization can be accepted as an original.*

I hereby authorize Charles H. Thorne, MD, ***PLLC*** *to furnish all information necessary including photographs to process my claims from this date forward to all of my insurance carrier, and to act on my behalf regarding insurance appeals. A copy of this signed authorization can be accepted as an original.*

*Signature*____________________ *Date*__________ *Guardian's DOB*_________

I authorize the release of my medical photographs for educational purposes, for literature, books, Internet, as well as for patient viewing. At no time will my name be mentioned unless agreed upon in writing under separate cover. (OPTIONAL)

*Signature*____________________________ *Date*_____________

HIPAA PRIVACY PRACTICES NOTIFICATION

I hereby acknowledge that I have been provided with the practice's NOTICE OF PRIVACY PRACTICES and that I have read and fully understand the notice. I have been provided the opportunity to ask questions about the notice and my questions have been answered to my satisfaction.

Patient Name: ____________________________________

⇒ ⇒ ⇒ ⇒ ____________________________________ ______________________

Signature of Patient **Date**

Witness Name: ____________________________________

⇒ ⇒ ⇒ ⇒ ____________________________________ ______________________

Signature of Witness **Date**