Patient Information

Date: ___/___/_____

Breast Care Center
Upstate University Hospital-Community Campus
4900 Broad Rd
Syracuse, NY 13215

UPSTATE COMMUNITY MEDICAL

Patient Demographics

Name (Last, First, MI)	Social Security	Birthdate	Sex	**(Check preferred 1st contact number)** ☐ Home Phone ( ) - ☐ Cell ( ) -

Mailing Address	City	State	Zip code	Marital Status

Employer	☐ Full time ☐ Part time	Address	City	State	Zip code	☐ Work Phone ( ) - ext:

Email Address	**Emergency Contact**	Relationship	Home Phone	Cell Phone

Race	Ethnicity (Hispanic/Non-Hispanic)	Language

Primary Care Physician	Referring Physician	Referring Address	Phone number Fax number

Insurance Information

Name of Primary Insurance Company	Policy Number/Group	Policy Holders Name, DOB. SSN	Co-payment Y/N Amount $_____
Name of Secondary Insurance Company	Policy Number	Policy Holders Name, DOB. SSN	
Name of Third Insurance Company	Policy Number	Policy Holders Name, DOB. SSN	

Responsible Party (If under 18 years of age)

Name (Last, First, MI)	Social Security	Birthdate	Sex	Home Phone ( ) - Cell ( ) -

Mailing Address	City	State	Zip Code	Marital Status

Employer	Address	City	State	Zip Code

Patient Release:
I certify the information that I have provided is correct, I authorize the release of medical information necessary to process insurance claims to companies or their agencies (including Medicare), for purpose of filing and payment of medical claims. I authorize payment of medical benefits to provider. I ACKNOWLEDGE THAT INTEREST OF A FEE, A THE PROVIDERS CURRENT RATE, MAY BE CHARGED on all balances owing to provider that are past due.
I permit a copy of this release to be used in place of the original.

Signature: _____ Date: _____
(Signature of insured or authorized person, patient, or parent if minor)