North Suffolk Endocrinology, PC
Joseph C. Terrana, MD, FACE

Patient Information

Name:____ Sex: M or F

DOB:____________ SSN:____________________ Marital Status: S M D W

Address: ____

City:____________________________________ State:____________ Zip:_______________

Home Phone:_______________________________ Cell #:___________________________

Preferred Phone number to confirm appointments: Home Cell Work

Emergency Contact (name and phone number)____

Preferred Pharmacy (name and phone number)____

Referring Doctor (First and last name) _____________________________________ Phone #__________________

Primary Care Physician (First and last name) ________________________________ Phone #__________________

Employed: YES or NO If yes, Full Time___________ Part Time___________

Employer Name:____ Work Phone:______________________

Insurance Information

Primary Insurance Company:____

Policy Holder Name:____ Policy Holder's DOB:________________

Identification/Member ID #______________________________________ Group #:__________________________

Insurance Company Phone # and Address:____

Secondary Insurance Company:____

Policy Holder Name:____ Policy Holder's DOB:________________

Identification/Member ID #______________________________________ Group #:__________________________

Insurance Company Phone # and Address:____

In Consideration of services rendered by North Suffolk Endocrinology, PC to the undersigned patient or guardian, the undersigned promises to pay North Suffolk Endocrinology any co-payment, coinsurance or other charges required to be paid as stated by their health insurance coverage. In addition, they promise to pay for all services that are not covered by their health insurance plan, provided they are informed of that prior to those services being rendered.

I have read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

Signature:____ Date:_____________________

Office Use only:
Photo Id verified:

Over Please -->