SUFFOLK BEHAVIORAL MEDICINE P.C.

MULCHAND CHUGH, M.D.

1097 Old Country Road, Suite # 105
Plainview, NY –11803

DATE: _____

PATIENT'S NAME _____ DATE OF BIRTH_____

SEX_____ SOCIAL SECURTY NUMBER (SSN) _____

HOME ADDRESS_____

CITY_____STATE_____ ZIP CODE_____

HOME PHONE_____ WORK/CELL PHONE_____

BY CHECKING THE BELOW BOX, I AGREE TO USE OF MY PHONE NUMBER FOR SMS MESSAGING BY SUFFOLK BEHAVIORAL MEDICINE FOR APPOINTMENT REMINDERS/CONVERSATIONAL USES. YOU MAY REPLY STOP TO OPT-OUT AT ANY TIME. MESSAGE AND DATA RATES WILL APPLY. MESSAGE FREQUENCY MAY VARY. MORE DETAILS IN THE PRIVACY POLICY ON OUR WEBSITE (CHUGHMD.COM) ☐

PATIENT OR PARENT'S EMAIL ID _____

NEXT OF KIN (IN CASE OF EMERGENCY) CONTACT (INFO) _____

PHONE NUMBER OF NEXT OF KIN_____

REFERRED BY _____

PRIMARY INSURANCE INFORMATION

Insurance Company Name: _____Policy Holder's ID Number:___ _____
Policy Holder Name: _____Policy Holder SSN_____
Policy Holder DOB: _____ Policy Holder's Tel Number _____
Policy Holder address_____City_____Zip_____
Policy Holder Employment Information_____

SECONDAY INSURANCE INFORMATION

Secondary Insurance Company Name: _____ Policy Holder's ID Number: _____
Policy Holder Name: _____ Policy Holder's Tel Number _____
Policy's Holder's DOB: _____ Policy's Holder's Relation to Patient: _____
Policy Holder address_____City_____Zip_____

CURRENT MEDICATIONS IF ANY_____
_____

MEDICAL PROBLEMS_____
_____
MEDICATION ALLEGIES_____
OTHER ALLERGIES _____
PHARMACY-NAME/ADDRESS/PHONE NUMBER _____
_____

I agree for treatment and will be responsible for all financial terms of my treatment and I allow Suffolk Behavioral Medicine P.C. and Dr. Mulchand Chugh to contact my insurance on my behalf to verify benefits and seek information as needed during the process of this treatment as per HIPPA law's.

Patient's OR Parents Signature: _____