JOSEPH B. NEIMAN, M.D., F.A.A.D.
1140 Youngs Road, Williamsville, NY 14221 – 716-688-0020 – Facsimile 716-688-2328 – www.neimandermatology.com

Date: _____

Patient's Name First	Last	MI	Family Physician

Address				Emergency Contact _____
City	State	Zip		Relationship Phone ( )
Primary Phone ( )	Secondary Phone ( )			**Responsible Party: □SELF □OTHER (list below)** Legal Guardian Relationship
Email				_____ _____ _____ _____
Date of Birth	Age	Sex	Marital	Primary Phone Secondary Phone ( ) ( )

Occupation	Social Security #
Pharmacy Location	Phone ( )

DO YOU HAVE MEDICAID PRESCRIPTION COVERAGE? ☐ **YES**
(Includes: MediSource, Healthy NY, YourCare, or others) ☐ **NO**

INSURANCE INFORMATION

Primary Insurance Plan

☐ Aetna	☐ Independent Health	☐ Univera
☐ BlueCross/BlueShield of Western NY	☐ Medicare ID: _____	☐ YourCare
☐ BlueCross/BlueShield Other	☐ Tricare ID: _____	☐ Other _____
☐ Empire Plan	☐ United Health	☐ **SELF PAID**

Secondary and Other Insurance Plan(s):

_____

Please specify any method or personnel we may *NOT* contact you by or through regarding your medical care:

□Home Phone □Cell Phone □Text Message □Work Phone □E-Mail □Mail □Another Person

If there are any restrictions to how we may contact you in regards to your on-going care, please explain in the space provided.