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)**
Email				Legal Guardian ____________ / Relationship ____________
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.