NYU Langone
MEDICAL CENTER

Faculty Group Practice Patient Demographic Form

Patient Information

Name (Legal Last, First, MI and *Chosen Name*)		Email address	
EPSTEIN, JEFFREY		jeevacation@gmail.com	
Street Address	**City**	**State**	**Zip**
9 EAST 71ST STREET	NEW YORK	NY	10021
[redacted]			Preferred ☑
JAN 20, 1953	M	Marital Status: ☑ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Partner ☐ Other	
Race	**Ethnicity**	**Preferred Language**	**Country of Origin**
		ENGLISH	USA

Financially Responsible Party

Is patient responsible party/guarantor? ☑ Yes ☐ No (If you are over the age of 18 and not in the care of an institution you are the guarantor as you are the person financially responsible for any charges you may incur during your visit)

Name	Address	City/State/Zip	Relationship to Patient
JEFFREY EPSTEIN	9 EAST 71ST ST, NY, NY	NY, NY 10021	SELF
Occupation	**Employer**	**Email Address**	**Date of Birth**
BANKER	SOUTHERN TRUST CO.	jeevacation@gmail.com	1-20-53
Home Phone	**Work Phone**		
[redacted]			Preferred ☑

Emergency Contact

Name	Relationship to Patient	
KARYNA SHULIAK	FRIEND	
Home Phone ( ) Preferred ☐	Work Phone ( ) Preferred ☐	[redacted] Preferred ☑

Referral Info

Referring Physician's Name	
DR. BRUCE MOSKOWITZ	[redacted]
Physician Address	
1411 N. FLAGLER DR., SUITE 7100, WEST PALM BEACH, FL 33401	

PCP Info

Primary Care Physician's Name (Check if same as Referring Physician above ☑)	Physician Phone/Fax (if known)
	( )
Physician Address	

Insurance Information

Primary Insurance Company		Group #
MEDICARE	[redacted]	
Patient's Relationship to Insured: ☑ Self ☐ Spouse ☐ Child ☐ Other	Name of Subscriber (if other than patient)	
[redacted] Gender: M	Date of Birth: 1-20-53	Employer of Subscriber: STC

Secondary Insurance Company	Policy #	Group #
UNITED HEALTHCARE CHOICE PLUS	911-87726-04	272605
Patient's Relationship to Insured: ☑ Self ☐ Spouse ☐ Child ☐ Other	Name of Subscriber (if other than patient)	
[redacted] Gender: M	Date of Birth: 1-20-53	Employer of Subscriber: STC

By signing below, I acknowledge that the information I provided is correct to the best of my ability.

Patient Signature: _____ Date: 7/11/18

Guarantor Signature (if other than patient): _____ Date: ___/___/___

Form Revised: 3/23/2017