The Westchester Headache Center

Patient Information Form

Please print

Last Name:_____First Name:_____ MI:_____

Social Security #:_____ Date of Birth:_____

Patient Home Tel. #: _____ Sex: _____ Marital Status:_____

Address:_____

City:_____ State_____ Zip:_____

Emergency Contact:_____ Tel. #:_____

Referring Physician:_____ Tel. #:_____

Family Physician:_____ Tel. #:_____

Patient's Employer:_____Work Tel. #:_____

Employers Address:_____City:_____St:_____Zip:_____

Occupation:_____

I hereby assume 100% responsibility for payment for all services when rendered. I hereby further authorize the Westchester Headache Center to charge the credit card listed below in the amount of $200 in the event that I fail to notify their offices of my inability to keep a scheduled appointment at least 24 hours in advance of said appointment.

VISA - M/C - AMEX - DSCVR	Credit/Debit Card Number	Expr.	Sec. Code

Signature (Guardian Signature if patient is under 18 years of age) Relationship Date

I Authorize Westchester Headache Center to release any medical information necessary to process all insurance claim's.

Signature (Guardian Signature if patient is under 18 years of age) Relationship Date

I Authorize (assign) payment of all claims to be made directly to Richard N.Silverstein, MD.

Signature (Guardian Signature if patient is under 18 years of age) Relationship Date