

**Joan and Sanford I. Weill**  
Medical College

**David J. Wolf, M.D., F.A.C.P.**  
*Clinical Associate Professor of Medicine*  
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**NEW PATIENT FORM**

DATE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

NAME: \_\_\_\_\_ SOCIAL SECURITY# \_\_\_\_\_

ADDRESS: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_ E-MAIL: \_\_\_\_\_

WORK PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

WHO REFERRED YOU TO DR. WOLF?: \_\_\_\_\_

WHEN WOULD YOU LIKE TO HAVE AN APPOINTMENT WITH DR. WOLF? \_\_\_\_\_

WHAT IS THE REASON YOU AND YOUR REFERRING DOCTOR ARE REQUESTING A CONSULTATION WITH DR. WOLF?  
\_\_\_\_\_

DO YOU HAVE MEDICARE?  YES  NO

SPECIFY PRIMARY INSURANCE: \_\_\_\_\_ POLICY # \_\_\_\_\_

SPECIFY SECONDARY INSURANCE: \_\_\_\_\_ POLICY # \_\_\_\_\_

TYPE OF INSURANCE PLAN:  POS  PPO  HMO  INDEMNITY  OTHER  UNCERTAIN

ARE YOU CURRENTLY UNDER THE CARE OF THE FOLLOWING PHYSICIANS:

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_ SPECIALTY: \_\_\_\_\_

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_ SPECIALTY: \_\_\_\_\_

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_ SPECIALTY: \_\_\_\_\_

ANYTHING YOU WISH DR. WOLF TO KNOW AT THIS TIME: \_\_\_\_\_  
\_\_\_\_\_

*CANCELLATION POLICY: Cancellations must be made at least 24 hours in advance of your scheduled consultation/new patient appointment, or you will be responsible for paying Dr. Wolf \$250.00 within 30 days following the scheduled appointment.*

To the best of my knowledge, the above information is accurate and complete.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

If you have not received a response from this office within 3 business days, please call (212) 688-7100, prompt #2.