

## Primary Provider: Dr. Sawey Harhash, MD

### Patient Demographics

|                           |                           |                            |                        |
|---------------------------|---------------------------|----------------------------|------------------------|
| <b>First Name</b>         | Justine                   | <b>Country</b>             | UNITED STATES          |
| <b>Nick Name</b>          |                           | <b>Street Address</b>      | 40 Pointe Circle South |
| <b>Middle Name</b>        |                           | <b>Zip Code</b>            | 11727                  |
| <b>Last Name</b>          | Carter                    | <b>City</b>                | Coram                  |
| <b>Suffix</b>             |                           | <b>State</b>               | NY                     |
| <b>Home #</b>             |                           | <b>Emerg Cont Name</b>     |                        |
| <b>Cell #</b>             | (631) 896-6397            | <b>Emerg Cont Phone</b>    |                        |
| <b>Work #</b>             |                           | <b>Emerg Cont Relation</b> |                        |
| <b>Work # Extension</b>   |                           | <b>Resp Party Name</b>     |                        |
| <b>Email</b>              | justinecarter23@gmail.com | <b>Resp Party DOB</b>      |                        |
| <b>Social Security #</b>  |                           | <b>Resp Party Relation</b> |                        |
| <b>Date of birth</b>      | 1999-08-23                | <b>Resp Party Phone</b>    |                        |
| <b>Sex</b>                | Female                    | <b>Resp Party Email</b>    |                        |
| <b>Race</b>               |                           |                            |                        |
| <b>Ethnicity</b>          |                           |                            |                        |
| <b>Marital Status</b>     |                           |                            |                        |
| <b>Preferred Language</b> |                           |                            |                        |
| <b>Student Status</b>     |                           |                            |                        |
| <b>Referred By</b>        |                           |                            |                        |

### Primary Insurance

**First**  
**Middle**  
**Last**  
**Suffix**  
**Date of Birth**  
**SSN**  
**Relation**  
**Insurer**  
**Payer ID**  
**ID #**  
**Group #**  
**Plan Name**  
**Claim Office**

### Secondary Insurance

**First** \*name of insured  
**Middle**  
**Last**  
**Suffix**  
**Date of Birth**  
**Social Security #**  
**Relation**  
**Insurer**  
**Payer ID**  
**ID #**  
**Group #**  
**Plan Name**  
**Claim Office**

### Tertiary Insurance

First  
Middle  
Last  
Suffix  
Date of Birth  
SSN  
Relation  
Insurer  
Payer ID  
ID #  
Group #  
Plan Name  
Claim Office

### Auto Accident Insurance

First  
Middle  
Last  
Suffix  
Date of Birth  
Social Security #  
Auto Accident Insurance Company  
Case #  
Mailing Address  
Zip Code  
City  
State  
Date of Accident  
State of Accident Occurrence

Travelers Insurance  
IIK2968  
P.O. box 430  
14240  
Buffalo  
NY  
2021-05-04  
NY

### Worker's Compensation

Worker Comp. Provider  
Mailing Address  
Zip Code  
City  
State  
Date of Accident  
Worker Comp. W.C.B.  
Worker Comp. Case #  
State of Accident Occurrence

### Durable Medical Equipment

Dme insurance company  
Dme insurance payer id  
Dme insurance plan name  
Dme insurance plan type  
Dme insurance id number  
Dme insurance group number  
Dme insurance notes

### Custom Demographics

2nd accident