REGISTRATION FORM

Instructions: Fill in the blanks. Please replace any Incorrect or outdated information.

PATIENT INFORMATION

Patient Name	Sex	DOB	Age	SSN	Marital Status	IDX MRN

Address	City, State	Zip

Home Phone	Home Fax#	Cell Phone	Email Address

Employer Name	Employer Address	City, State	Zip	Work Phone	Work Fax#

Preferred Language	Ethnicity	Race
	○ Hispanic/Latino ○ Non Hispanic/Latino ○ Declined	○ Afr American ○ Natv Hawaii/Pac Isl ○ Unknown ○ Asian ○ White ○ Declined ○ Natv Amer/Alaskan ○ Other/Multiracial

Emergency Contact

Contact Name	Relationship	Home Phone	Work Phone

ician Information

Referring Physician's Name			
Address	**City, State**	**Zip**	**Phone**
Primary Care Physician Name			
Address	**City, State**	**Zip**	**Phone**

Insurance Information

PRIMARY Insurance Name	Certificate/Policy #		Group #	Phone
Address	**City, State**			**Zip**
Insured's Name	**Relation to Insured**	**Insured's DOB**	**Effective Date**	**Expiration Date**
SECONDARY Insurance Name	**Certificate/Policy #**		**Group #**	**Phone**
Address	**City, State**			**Zip**
Insured's Name	**Relation to Insured**	**Insured's DOB**	**Effective Date**	**Expiration Date**

ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I certify that all information above is true and correct. I authorize and direct North Shore LIJ Health Systems, having treated me, to release to governmental agencies, insurance carriers or others who are financially liable for my medical care, all information needed to substantiate payment for such medical care and permit representatives thereof to examine and make copies of all records relating to such care and treatment. I hereby assign, transfer and set over to North Shore LIJ Health Systems sufficient monies and or benefits to which I may be entitled from governmental agencies, insurance carriers or others who are financially liable for my medical care to cover the costs of the care and treatment rendered to myself or my dependents. I request that payment of authorized benefits be made on my behalf, and I understand I am responsible for charges not covered by policy or plan.

(Medicare) I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the SS Administration snd HCFA or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician furnishing the services or authorize such physician to submit a claim top Medicare for payment to me.

_____ _____

Signature of Patient or Authorized Guardian *Date*

AUTHORIZATION TO RELEASE INFORMATION VIA E-MAIL

By providing your e-mail address you agree to receive by e-mail address information about your healthcare, including protected health information.

_____ _____

Signature of Patient or Authorized Guardian *Date*