Patient Appointment Information				
Name of Physician	**Provider #**	**Appt Date**	**Appt Time**	**Appt #**

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 Please replace any Incorrect or outdated information.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#**

Emergency Contact			
Contact Name	**Relationship**	**Home Phone**	**Work Phone**

Physician Information			
Referring Physician's Name			
Address	**City, State**	**Zip**	**Phone**
Primary Care Physician Name {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 entitiled from governmental agencies, insurance cariers 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 carrieers 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 e-mail address information about your healthcare, including protected health information.

_____ _____

Signature of Patient or Authorized Guardian Date

PRIMARY LANGUAGE SPOKEN: _____