NewYork-Presbyterian
Brooklyn Methodist Hospital

PATIENT REGISTRATION FORM

(Please print and complete the forms before your appointment.
You will need to bring these forms to your appointment – thank you.)

DATE:_____ HOME TELEPHONE:_____ CELL:_____

PATIENT:_____
LAST NAME FIRST NAME MIDDLE INITIAL

STREET ADDRESS:_____APT# _____

CITY:_____ STATE:_____ ZIP CODE:_____

SEX: M_____F_____ AGE:_____ BIRTH DATE:_____SINGLE:_____M_____W_____D_____

PATIENT EMPLOYED BY:_____

BUSINESS ADDRESS:_____

OCCUPATION:_____BUSINESS PHONE:_____

SOCIAL SECURITY #_____ E-MAIL:_____

DO YOU HAVE MEDICAL INSURANCE: YES _____ NO _____

WHO IS RESPONSIBLE FOR THIS ACCOUNT?:_____D.O.B_____

RELATIONSHIP TO PATIENT:_____SOCIAL SECURITY:_____

NAME OF PRIMARY INSURANCE:_____

ID #:_____ GROUP#:_____ OTHER:_____

NAME OF SECONDARY INSURANCE:_____

ID #:_____ GROUP#:_____ OTHER:_____

IF YOU DO NOT HAVE INSURANCE, PLEASE INDICATE HOW YOU WILL PAY FOR YOUR MEDICAL SERVICES?:

_____1. PAY BALANCE IN FULL AT TIME OF VISIT
_____2. MAKE PAYMENT ARRANGEMENTS PRIOR TO SERVICE

IN CASE OF AN EMERGENCY, WHO SHOULD BE NOTIFIED?:_____

RELATIONSHIP TO PATIENT:_____TELEPHONE:_____

ADDRESS:_____

PHARMACY NAME:_____TELEPHONE:_____

HOW DID YOU LEARN OF OUR PRATICE?:_____

REFERRING PHYSICIAN'S NAME?:_____

ADDRESS:_____TELEPHONE:_____

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ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressively agree and acknowledge that my signature on this document authorized my physician to submit claims for benefits for service rendered or for services to be rendered without obtaining my signature on each and every claim submitted for myself and/or dependents, and I will be found by this signature as though the undersigned had personally signed the particular claim.

Patient's Signature: X_____

Participating Insurance (Including Medicare) Patients

I understand that _____ as a participating provider, has agreed to bill my insurance carrier for services rendered today. I further understand that based on the terms of my contract with my insurance company, I MAY, be responsible for copay, deductible and/or coinsurance. I will be responsible for the full balance in the event of denial due to policy restrictions by my insurance carrier.

Patient's Signature: _____

Non-Participating Insurance Patients

I understand that _____ has agreed to billing my insurance company for the examination performed today and that I am responsible for any and all balances regardless of deductible and/or insurance allowable. I also agree to forward immediately any insurance payments that I receive for these services. I request that payment of authorized insurance benefits be made on

my behalf to _____, for services rendered today.

Patient's Signature: _____

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I _____ hereby authorize _____to pay and hereby
(Insured's Name) (Insurance Company)

assign directly to _____ all benefits, if any, otherwise payable to me for his/her
(Doctor's Name)

services as described on the attached forms. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by paid to

_____ will be credited to my account in accordance with the above said assignment.
(Doctor's Name)

_____ _____
(Authorized Signature of Subscriber) (Date)