Patient Appointment Information						
Attending Physician:	**Sched Resource:**	**Appt Date:**	**Appt Time:**	**Encounter #:**	**MGMRN#:**	**Activity Type:**

REGISTRATION FORM

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 Please replace any incorrect or outdated information.

Patient Information

Patient Name:	**Gender:**	**DOB:**	**Race:**	**Ethnicity:**	**Preferred Language:**
Address:			**City State Zip:**		
Home Phone:	**Cell Phone:**	**Email Address:**		**Appointment Reminder:**	
Employer Name:		**Employer Address:**			
HIPAA Statement Provided:		**Date Provided:**		**HIPAA Statement Signed:**	

Contact Information

Contact Name and Relationship: (Patient is:)	**Contact Type:** Emergency	**Preferred Phone:**	**Alternate Phone:**
Contact Name and Relationship: (Patient is:)	**Contact Type:** Next Of Kin	**Preferred Phone:**	**Alternate Phone:**

Guarantor Information

Guarantor Name:	**Guarantor Address:**	**City State Zip:**	
Relationship of Patient:	**Home Phone:**		**Guarantor DOB:**

Physician Information

Referring Physician's Name:	**Phone:**
Primary Care Physician Name:	**Phone:**

Insurance Information

Primary Insurance Name:	**Subscriber's Name:**	**Subscriber's DOB:**	**Subscriber's Relation to Patient:**
Address:		**Group #:**	**Phone:**
Secondary Insurance Name:	**Subscriber's Name:**	**Subscriber's DOB:**	**Subscriber's Relation to Patient:** Subscriber is:
Address:		**Group #:**	**Phone:**

ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I certify that all information above is true and correct. I authorize and direct Northwell Health Physician Partners, 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 Northwell Health Physician Partners 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 and 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 to Medicare for payment to me.

_____ _____

Signature of Patient or Authorized Guardian *Date*

(User ID/Dt: ,)