



2 Medical Park Drive Suite 3 • West Nyack, New York 10994

PATIENT REGISTRATION FORM

Last Name _____ First Name _____ Middle Name _____

Address _____

City _____ State _____ Zip _____

Phone (H) _____ (C) _____ (W) _____ Ext: _____

Date of Birth _____ Age _____ Gender: Male Female

Email: _____ SSN _____

Pharmacy Name _____

Pharmacy Address _____

Pharmacy Phone _____ Pharmacy Fax# _____

Referred By: _____

Emergency Contact Info

Name _____

Relationship Spouse Child Mother Father Sibling Other _____

Phone _____

Status

Employment Full-Time Part-Time Retired Self-Employed Not-Employed Active Military Duty Unknown N/A

If Employed, please fill out the following: Occupation: _____

Employer Name: _____

Employer Address: _____

Employer Phone: _____

Student Full-Time Part-Time N/A

Marital Status Single Married Separated Divorced Widowed Unknown N/A

If Married, please fill out the following: Name of Spouse: _____ Spouse's DOB: _____

Spouse's Occupation: _____ Spouse's Work Phone: _____

Spouse's Employer Address: _____

Guarantor Information

Medicare? Y N If yes, Medicare number: _____ Is Medicare your Primary Insurance or Secondary Insurance?



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Guarantor Information (Cont'd)
Primary Insurance

Relationship to Insured Self Spouse Child Mother Father Sibling Other _____

Insurance Company _____ *Claim Send to Address:*

Insurance Plan _____

Insured Member# _____

Patient Insurance# _____

Start Date Effective _____ End Date Effective _____

Co-Payment _____ Annual Deductible _____ Group# _____

Insured's Information

Last Name _____ First Name _____ Middle Name _____

Address _____

City _____ State _____ Zip _____

Phone (H) _____ (C) _____ (W) _____ Ext: _____

DOB _____ Age _____ Gender: Male Female

Secondary Insurance

Relationship to Insured Self Spouse Child Mother Father Sibling Other _____

Insurance Company _____ *Claim Send to Address:*

Insurance Plan _____

Insured Member# _____

Patient Insurance# _____

Start Date Effective _____ End Date Effective _____

Co-Payment _____ Annual Deductible _____ Group# _____

Insured's Information

Last Name _____ First Name _____ Middle Name _____

Address _____

City _____ State _____ Zip _____

Phone (H) _____ (C) _____ (W) _____ Ext: _____

DOB _____ Age _____ Gender: Male Female



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Tertiary Insurance

Relationship to Insured Self Spouse Child Mother Father Sibling Other _____

Insurance Company _____ *Claim Send to Address:*

Insurance Plan _____

Insured Member# _____

Patient Insurance# _____

Start Date Effective _____ End Date Effective _____

Co-Payment _____ Annual Deductible _____ Group# _____

Insured's Information

Last Name _____ First Name _____ Middle Name _____

Address _____

City _____ State _____ Zip _____

Phone (H) _____ (C) _____ (W) _____ Ext: _____

DOB _____ Age _____ Gender: Male Female

MEDICARE BENEFICIARY SIGNATURE ON FILE:

I authorize any holder of medical or other information about me to release to the Social Security Administration and the Centers for Medicare and Medicaid Services or their intermediaries or carriers, or to the billing agent of the above named medical practice, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

Signature: _____ Date: _____

RELEASE OF MEDICAL INFORMATION:

I authorize the release of any medical or other information necessary to process this claim(s). I also authorize the release of any medical or other information to any other treating physician(s).

Signature: _____ Date: _____

MEDIGAP WAIVER:

I request that payment of authorized Medigap benefits be made either to me or on my behalf to the provider of service and (or) supplier for any services furnished to me by the provider of service and (or) supplier. I authorize any holder of Medicare information about me to release to my Medigap insurance any information needed to determine these benefits payable for related services.

Name of Medigap Insurance: _____ HIC#: _____

Signature: _____ Date: _____

HCSS11162009