Patient Appointment Information

Name of Physician	Provider #	Appt Date	Appt Time	Appt #	MGMRN#:

Northwell Health Physician Partners

REGISTRATION FORM

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 Please replace any Incorrect or outdated information.

Patient Information

Patient Name	Gender	DOB	SSN	Race	Ethnicity	Preferred Language

Address	

Home Phone	Home Fax#	Cell Phone	Email Address

Employer Name	Employer Address	Work Phone

Emergency Contact

Name	Relationship	Home Phone	Work Phone
Guarantor Name	**Relationship**	**Home Phone**	**Work Phone**
Other Name	**Relationship**	**Home Phone**	**Work Phone**

Physician Information

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

Insurance Information

PRIMARY Insurance Name	Certificate/Policy #	Group #	Phone

Address

Insured's Name	Relation to Insured	Insured's DOB	Effective Date	Expiration Date

SECONDARY Insurance Name	Certificate/Policy #	Group #	Phone

Address

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 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 top Medicare for payment to me.

_____ _____

Signature of Patient or Authorized Guardian *Date*

(User ID/Dt: , 09/1/1885 15:05)