



PATIENT REGISTRATION FORM

For Office Use Only: WC NF PPO MCR COM HMO DOC: RMK NGB JAG HSB ADB SGJ JLZ MML

Date: ___ / ___ / ___

GENERAL INFORMATION

Patient's Name: _____

Street: _____ Apt. _____
Last Name First Name Middle I

City: _____ State: _____ Zip: _____

Home Phone # () _____ - _____ Work Phone: # () _____ - _____

Email: _____

Date of Birth: Month: _____ Day: _____ Year: _____ Age: _____ Sex: Female Male

Social Security #: _____ - _____ - _____ Marital Status Married Divorced Widow Single

Employer: _____ Occupation: _____

Employer's Address: _____ City: _____ State: _____ Zip: _____

Spouse/Guarantor's Social Security # _____ - _____ - _____ Work Phone # () _____ - _____

Guarantor's Name _____ Employer: _____

Employer's Address: _____ City: _____ State: _____ Zip: _____

RESPONSIBLE PARTY INFORMATION

If Patient is child, Name of Guarantor: _____

Street Address (if different than above): _____

City: _____ State: _____ Zip: _____

HOW WERE YOU REFERRED TO OUR OFFICE?

Previously seen in our office: yes no. Referred by: _____

Referring Doctor's Name: _____

Address: _____ Phone #: _____

City: _____ State: _____ Zip: _____

Who is your General Medical Doctor: _____

Address: _____ Phone #: _____

City: _____ State: _____ Zip: _____

Attorney's Name: _____

Address: _____ Phone #: _____

City: _____ State: _____ Zip: _____

Medical Group / Insurance Co. Name: _____

Address: _____ Phone #: _____

City: _____ State: _____ Zip: _____

INSURANCE INFORMATION (Commercial/POS/PPO/HMO/Medicare)

Patient's Name: _____

Primary Insurance Company: _____ ID/POLICY#: _____

Plan Name: _____ Group#: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Insured Name (If other than Patient): _____

Relationship to the Insured: Self Spouse Child

Secondary Insurance Company: _____ ID/Policy#: _____ Group#: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Insured Name (If other than Patient): _____

Relationship to the Insured: Self Spouse Child

WORKERS' COMPENSATION INFORMATION (If injured at work, please complete)

Date of Accident: ___/___/___ Place of Accident: _____ State: _____

Employer at the time of Injury: _____ Phone () _____ - _____

Address: _____ City: _____ State: _____ Zip: _____

Insurance Company: _____

Address: _____ City: _____ State: _____ Zip: _____

Carrier Case #: _____ WCB #: _____ Policy #: _____

Has a report been filed by your employer?: Yes No If yes, when _____

NO FAULT (If injured in an auto accident, please complete)

Date of Accident: ___/___/___ Place of Accident: _____ State: _____

Insurance Company: _____ Phone () _____ - _____

Address: _____ City: _____ State: _____ Zip: _____

Has the accident been reported to this insurance company?: Yes No If yes, when _____

Insured's Name (If other than Patient) : _____

Policy #: _____ Claim #: _____

Registrar Comments: _____

Patient's Signature **X** _____ Date: ___/___/___ Registrar Initials _____

Input Date: _____/_____/_____



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Downtown Physical Medicine & Rehabilitation*

*Medical Pain Management
Seaport Podiatry*

ASSIGNMENT FORM

Authorization for Insurance Submissions

I authorize the use of this form on all insurance submissions.

Authorization to Release Medical Information

I authorize the release of medical information pertaining to my history, services rendered or treatment given to me or my dependent for purposes of review of my insurance claims.

Assignment Authorization

I hereby authorize payment of benefits to be made to the physician rendering services. I will be held responsible for any costs which are not covered by my insurance carrier, including any deductible, co-insurance, co-pay, denied or any uncovered services.

Non-Participating Insurance Provider

I understand that if I am examined by a physician that does not participate with my insurance, I will receive payment directly from the insurance carrier. I understand fully that it is my responsibility to sign over all payments, including the Explanation of Benefits (EOB), to the examining provider.

Signature of Patient or Legal Guardian

Date Signed

Please Print Your Name

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW ASSIGNMENT OF BENEFITS FORM

I, _____ ("Assignor") hereby assign to the above named providers ("Assignees") all rights, privileges and remedies to payment for health care services provided by Assignees to which I am entitled under Article 51 (No-Fault statute) of the Insurance Law.

The Assignees hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignees for injuries sustained due to the motor vehicle accident which occurred on _____, not withstanding any prior written agreement to the contrary.

This agreement may be revoked by the assignee when benefits are not payable based upon the Assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the Assignor.

ANY PERSONS WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIAL FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR SUCH VIOLATION.

Print Name of Patient

Date

Print Name of Provider

Signature of Patient

Signature of Provider

Address: _____

Address: _____