

DEPARTMENT OF OTOLARYNGOLOGY
NEW YORK EYE & EAR INFIRMARY

Patient Registration Form

Date: _____ Account # _____

Patient: This section refers to patient only

Last Name:			First Name:			MI:		
Address: Street and Number, Apt# /Box#			City		State		Zip code	
Home Telephone:			Work Telephone:			Social Security No:		
Date of Birth		Age:	Sex: M F	Marital Status: S M LP D W				
Source of Referral			Primary Care Physician's Name:					
Primary Care's Address:			City		State:		Zip code	
Primary Care's Telephone:								
Employer's Name:			Employer's Address Street and Number, Apt# /Box#					
City:		State:		Zip code:		Type of Business		
Spouse or Guardian:			Relationship to patient:					
Address: Street and Number, Apt# /Box#			City:		State:		Zip code	
Social Security No:		Date of Birth:			Age:			
Spouse's Employer's Name:			Employer's Address Street and Number, Apt# /Box#					
City:		State:		Zip code:		Type of Business		
Emergency Contact:		Emergency Telephone:						

Insurance Information: Please give us all pertinent information regarding your insurance coverage. If you have coverage by more than one carrier, supply information of both carriers. Please list all numbers on your card(s). Please check your insurance policy for a waiting period before coverage or pre-existing clauses. IF YOUR COVERAGE IS CONTINGENT ON A SECOND OPINION OR PRE AUTHORIZATION APPROVAL, PLEASE BE SURE TO TELL US.

PRIMARY Insurance Plan:			Policy No.:			Group No:		
Insurance Company Address:			City:		State:		Zip code:	
Subscriber's Name:		Patient's relationship to subscriber:			Date of Birth of Subscriber:			
Co-pay amount:		Effective date:		Termination date:				

SECONDARY Insurance Plan:			Policy No.:			Group No:		
Insurance Company Address:			City:		State:		Zip code:	
Subscriber's Name:		Patient's relationship to subscriber:			Date of Birth of Subscriber:			
Co-pay amount:		Effective date:		Termination date:				

TO MY INSURANCE CARRIER(S):

1. I authorize the release of any medical information necessary to process my insurance claim(s) to Medical Management Technologies.
2. I authorize the request for payment of medical benefits directly to my physicians, The New York Eye and Ear Infirmary.
3. I agree that this authorization will cover all medical services rendered until such authorization is revoked by me.
4. I agree that all photocopies of this form may be used in lieu of the original.
5. I agree to pay all charges not covered by my insurance carrier(s): these charge include but are not limited to deductibles and co-payments of my insurance policy.

Signature

Date