New York Physicians LLP
635 Madison Avenue • New York, New York 10022

Patient Registration Form

Name: ____ Date of Birth:__________________ Sex:_______

S.S. #: ____Email: ____________________________________

Email Consent: I authorize the use of unsecured (non-HIPAA-compliant) email for communication.
Yes_____ No_____ Please sign for consent: ____

Address: _______________________________________City/State/Zip#: ___________________________

Home Phone: __________________________________ Cell Phone:_________________________________

Day Phone:___________________________________ Fax:____

Preferred Contact Phone __ Home __ Cell __ Day Leave message okay? __ Home ___ Cell ___ Day

Emergency Contact: _____________________________ Relationship:________________________________

Emergency Contact Phone: ________________________

Preferred Pharmacy (name and phone): ____

Mail Order Pharmacy (name and phone): ____

Insurance Information

Primary Insurance: _________________________ **Secondary Insurance**:__________________________

Address: ____________________________________Address: _______________________________________

City/State/Zip: _______________________________City/State/Zip: _________________________________

Policy Holder: _______________________________Policy Holder: __________________________________

DOB: ____DOB: ____

Policy #: ____________________________________Policy #: ______________________________________

Group #: ____________________________________Group #: ______________________________________

Authorization and Signature on File:
I authorize the release of any medical information to my insurer and/or CMS and its agents to process my insurance claims. I authorize payment of benefit directly to New York Physicians LLP on my behalf. I agree that this authorization will cover all medical services rendered until such authorization is revoked by me. I agree that a photocopy of this form may be used in lieu of the original. I agree to pay all charges not covered or later to be determined to be ineligible by my insurance carrier(s). These charges include but are not limited to deductibles, coinsurance, and copayments on my insurance policy. If the doctor is not participating with my insurance plan or I have not obtained the proper insurance referrals and authorizations, I am responsible to pay the full bill for all services rendered.

Signature:____**Date:**__________________________________