Westchester Medical
Regional Physician Services, PC

REGISTRATION FORM (PLEASE PRINT)

Today's date:	Reason for visit:

PATIENT INFORMATION

Last name:	First:	Initial:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status «MaritalStatus»
					Single / Mar / Div / Sep / Wid

Email Address:	Social Security #:	Birth date:	Age:	Sex:	
«Email»				❑ M	❑ F

Address:	Home phone :	Mobile phone:
	«HomePhone»	

City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone #:

Please circle one:	Race: Asian / Black / Hispanic / Mixed Race / White / Other	Ethnicity: Hispanic / Non Hispanic	❑ Decline to Answer

How did you hear about us? (please check one box):			❑ Dr.		Preferred Language: ❑ English	
❑ Hospital	❑ Insurance Plan	❑ Family/Friend	❑ Yellow Pages	❑ Other	❑ Spanish	❑ Other_______________

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Insurance Policy Holder:	Birth date:	Policy Holder's S.S. #:	Policy#:	Group#:
	/ /			

Address (if different):			Telephone #:
City:	State:	Zip:	
Occupation:	Employer:	Employer address:	Employer phone #:
			( )

Patient's relationship to subscriber**:**	❑ Self	❑ Spouse	❑ Child	❑ Other

Secondary insurance (if applicable):	Subscriber's name:	Policy #:	Group #:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

REFERRING PHYSICIAN & PHARMACY INFORMATION

Referring Physician:			Specialty:	
Address:			Phone:	
City:	State:	Zip:	Pharmacy Name:	Phone:

IN CASE OF EMERGENCY

Name of Emergency Contact:	Relationship to patient:	Home phone :	Work phone :	Cell phone:
			( )	( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Westchester Medical Center Advanced Physician Services, PC or insurance company to release any information required to process my claims.

Patient Signature:	*Date:*
Patient/Guardian signature	*Date*