

PATIENT REGISTRATION

PHYSICIAN _____

Brooklyn Women's Services complies with the medical privacy regulations issued by the U.S. Department of Health & Human Services under the Health Insurance and Portability & Accountability Act (HIPAA) of 1996.

NAME _____ SEX _____ DOB _____ AGE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

Please indicate your preferred method of contact:

HOME PHONE (____) _____ CELL PHONE (____) _____ WORK PHONE(____) _____

Email address _____ MARITAL STATUS _____ SSN _____

WORK STATUS [] F/T [] P/T [] RETIRED [] STUDENT [] OTHER _____

EMPLOYER _____ ADDRESS _____

OCCUPATION _____

PRIMARY INSURANCE CO. _____ PHONE (____) _____

ID# _____ GROUP# _____ PLAN# _____

RELATIONSHIP TO INSURED [] Self [] Spouse [] Child [] Other _____

NAME OF INSURED _____ INSURED'S DOB _____

SECONDARY INSURANCE CO. _____ PHONE (____) _____

ID# _____ GROUP# _____ PLAN# _____

RELATIONSHIP TO INSURED [] Self [] Spouse [] Child [] Other _____

NAME OF INSURED _____ INSURED'S DOB _____

WHOM MAY WE THANK FOR REFERRING YOU? [] FRIEND _____ [] EVENT _____

[] INSURANCE _____ [] PHYSICIAN _____ [] ADVERTISEMENT _____

[] YELLOW PAGES [] MAILING [] WALK - IN [] OUR WEBSITE [] MAIMONIDES MEDICAL CENTER

[] OTHER _____

EMERGENCY CONTACT _____ PHONE (____) _____

RELATION _____

These providers are authorized to render services(s) to the undersigned and/or her/his dependent(s). I also authorize payment of insurance benefits when assignable To be made on my behalf to provider for services rendered. I understand eligibility must be verified for assigned insurance benefits and that charges during a lapse, in benefits, deductible periods, and coinsurance are my responsibility. I authorize Government benefits to Brooklyn Women's Services. I authorize photocopies of this form to be as valid as the original.

I authorize members and associates of these provider groups **access to my medical record** for the purpose of coordination of my medical care. I authorize **release of information** regarding medical treatment and related information to my health insurance company, Health Care Financing Administration, their authorized agents or intermediaries for the purpose of validating and determining benefits payable.

I authorize Brooklyn Women's Services staff to contact me and/or leave a message at the address, phone numbers and/or email address(es) provided above.

DATE

SIGNATURE OF PATIENT / PARENT / GUARDIAN / AUTHORIZED REPRESENTATIVE