

NYGA

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Patient Registration Sheet (Please Print)

CELL
PHONE:

| | | | |
|---|-------------------|--|-----------------|
| NAME (LAST, FIRST, MI) | | AGE | DATE OF SERVICE |
| SEX <input type="checkbox"/> M <input type="checkbox"/> F | DATE OF BIRTH | SS# | |
| STREET | | APT. # | |
| CITY | STATE | ZIP CODE | |
| HOME TEL () | WORK TEL () | EMAIL/FAX NO () | |
| OCCUPATION | BUSINESS/EMPLOYER | | |
| REFERRED BY | | | |
| REFERRING PHYSICIAN | | TEL () | |
| ADDRESS | | | |
| PRIMARY PHYSICIAN (IF DIFFERENT FROM ABOVE) | | TEL () | |
| ADDRESS | | | |
| PRIMARY INSURANCE | | | |
| SUBSCRIBER | DATE OF BIRTH | SS# | |
| RELATIONSHIP TO SUBSCRIBER | | | |
| POLICY # | GROUP # | IS THIS MANAGED CARE? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| EMPLOYER | | EFFECTIVE DATE OF COVERAGE | |
| SECONDARY INSURANCE | | | |
| POLICY HOLDER | POLICY # | GROUP # | |
| EMERGENCY CONTACT (RESPONSE REQUIRED) | | TEL () | |

Return completed form with your insurance card to the receptionist