DEPARTMENT OF OTOLARYNGOLOGY
NEW YORK EYE & EAR INFIRMARY

Patient Registration Form — Date: _________________ Account #_______________

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		
Email Address:			**Pharmacy Name and Telephone:**			
Primary Care Physician Name:			**Referring Physician's Name:**			
Primary Care Physician Address:			**Referring Physician's Address:**			
City:	**State:**	**Zip code:**	**City**	**State**		**Zip**
Primary Care Physician Telephone:			**Referring Physician's Telephone**			

Other Referral Source: Website______ Other Patient / Friend ________________________ Insurance Plan___________ Other: _______________

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:**		

Patient: This section refers to patient only

Insurance Information: Please give us all pertinent information regarding your insurance coverage. If you have coverage by more then 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:
Subscriber's Social Security Number	Effective date:	Termination date:		Copay Amount:

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:
Subscriber's Social Security Number	Effective date:	Termination date:		Copay Amount:

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 charges include but are not limited to deductibles and co-payments of my insurance policy.*

_________________________________ _________________________

Signature Date