SUNY Downstate Medical Center
University Hospital of Brooklyn

University Physicians Brooklyn, Inc.

Office location: ☐ UPB-ENT 185 Montague St ☐ UPB-ENT 376 6th Ave ☐ SUNY Suite H

OTOLARYNGOLOGY PRACTICE
New Patient Registration Record
Please Print

PATIENT NAME_____

LAST FIRST MIDDLE ☐ MALE ☐ FEMALE

HOME ADDRESS_____City_____ State_____ Zip_____

HOME PHONE ( )_____CELL/BEEPER ( )_____Work ( )_____

PATIENT'S SS#_____ PATIENT'S DATE OF BIRTH_____

INSURED'S SS#_____ INSURED DATE OF BIRTH_____

IF PATIENT IS A CHILD; PLEASE INDICATE PARENT/GUARDIAN'S NAME(S):

MOTHER:_____( ) _____ ( )_____

DAY PHONE CELL/BEEPER

FATHER:_____ ( )_____( )_____

DAY PHONE CELL/BEEPER

RESPONSIBLE PARTY FOR PAYMENT:_____

EMPLOYER:_____ TEL # ( )_____

EMPLOYER ADDRESS_____ City_____ State_____ Zip_____

PRIMARY INSURANCE_____ POLICY # _____

SECONDARY INSURANCE_____ POLICY # _____

My signature below indicates that I am requesting care in this office and consent to medical treatment. I authorize Dr. _____ to release medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I have insurance coverage with the above named company and assign directly to the physician all surgical and/or medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance.

Patient or Responsible Party Signature_____ Date:_____

In case of emergency whom should we contact?
Name_____ Relation to Patient_____

Address_____ City_____ State _____ Zip_____

DAY PHONE ( )_____ EVE/CELL/BEEPER ( )_____

Please provide your preference on how you would like your prescription processed:

☐ Local Pharmacy: Name & Address: _____ Phone #_____

☐ Mail Order: Name & Address or Location_____

How did you find out about our practice?

☐ Word of Mouth (friend, relative, colleague) ☐ Advertisement (Yellow Pages, etc.)

☐ Referred by other MD_____ address:_____

☐ Insurance or Managed Care Program ☐ Other_____

PRIMARY (PCP) DOCTOR _____PHONE ( )_____

ADDRESS _____ City_____ State_____ Zip_____

* PLEASE HAND IN THE FOLLOWING WITH THIS SHEET:

REFERRAL FORMS, INSURANCE FORMS, and INSURANCE CARD

THANK YOU!

ID #_____

Information verification

_____/_____ _____/_____

_____/_____ _____/_____

STAFF ONLY: Initials/date