North Shore LIJ

North Shore-Long Island Jewish Health System

Faculty Practice Plan
REGISTRATION FORM
Please Print Legibly

I. Patient Information:

Patient Name _____ (Last) _____ (First) **Sex** ___ M ___ F **Date of Birth** _____ / _____ / _____

Social Security # _____ - _____ - _____ **Marital Status** _____ (S M W D) **Home Telephone #** _____

Preferred Language _____ **Email Address** _____ **Cellular Phone #** _____

Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

Father's First Name _____ **Mother's First Name** _____ **Are you employed?** ___ Yes ___ No

Emergency Contact _____ **Telephone Number** _____ **Relationship** _____

II. Referring Physician:

Physician Name _____ (Last) _____ (First) **Telephone Number** _____

Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

Primary Care Physician (If Different from Above) _____ (Name) _____ (Address) _____ (City) _____ (State) _____ (Zip)

III. Employer Information:

Name of Employer _____ **Work Number** _____ **ext** _____

Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

IV. Spouse Information:

Spouse's Name _____ (Last) _____ (First) **Sex** ___ M ___ F **Date of Birth** _____ / _____ / _____

Spouse's Social Security # _____ - _____ - _____ **Spouse Employed by** _____

Spouse's Employer Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

Insurance Information: *(Please provide insurance cards for verification)*

V. PRIMARY **Insurance Coverage** _____ (Name of Insurance Carrier) **Relationship to Subscriber** _____ (Self, Spouse, Child, Student)

Subscriber's Name _____ (Last) _____ (First) **Subscriber's Date of Birth** _____ / _____ / _____

Subscriber's Social Security Number _____

Insurance ID Number _____ (Please provide number from Card) **Group Number** _____ **Plan Number** _____

Claims Address _____ (Street or PO Box) _____ (City) _____ (State) _____ (Zip)

VI. SECONDARY **Insurance Coverage** _____ (Name of Insurance Carrier) **Relationship to Subscriber** _____ (Self, Spouse, Child, Student)

Subscriber's Name _____ (Last) _____ (First) **Subscriber's Date of Birth** _____ / _____ / _____

Subscriber's Social Security Number _____

Insurance ID Number _____ (Please provide number from Card) **Group Number** _____ **Plan Number** _____

Claims Address _____ (Street or PO Box) _____ (City) _____ (State) _____ (Zip)

Authorization for release of information by Faculty Practice Plan at NSLIJ Health System

I hereby authorize and direct the above named faculty practice, having treated me, to release to government agencies, insurance carriers, or others who are financially liable for my medical care, all information needed to substantiate payment for such medical care and to permit representatives thereof to examine and make copies of all records relating to such care and treatment.

VII. _____ (Signature of Patient or Authorized Representative) _____ / _____ / _____ (Date)

I hereby assign, transfer, and set over to the above named faculty practice sufficient monies and/or benefits to which I may be entitled from governmental agencies, insurance carries, or others who are financially liable for my medical care to cover the costs of the care and treatment rendered to myself or my dependent in said practice.

VIII. _____ (Signature of Patient or Authorized Representative) _____ / _____ / _____ (Date)