Phelps Medical Associates
Northwell Health

Registration Form

Last Name: _____ First Name: _____ Date of Birth: _____

Address: _____ Apt#:_____

City: _____ State: _____ Zip Code: _____

Sex: □F □ M □ Transgender Marital Status: □ Married □ Single □ Widowed □ Divorced □ Life Partner

Email Address: _____

Home #:_____ Cell#:_____ Work#:_____

Preferred Method of Contact: _____ Preferred Language: _____

Do you have any communication barriers? ☐ None ☐Hearing ☐Vision ☐ Cognitive?

Race: ☐ American Indian/Alaska Native ☐Asian ☐ Black/African American ☐ White ☐ Other ☐ Unknown

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown Religion: _____

Primary Care Physician: _____ Referring Physician: _____

Preferred Pharmacy: Name_____ Address/Phone Number: _____

<u>Patient Employer:</u>

Name: _____ Occupation: _____ ☐Retired ☐Unemployed

Address: _____ City: _____ ☐Student ☐ Other_____

State: _____ Zip Code: _____ Phone#:_____

<u>Insurance:</u>

Name of Insurance: _____ Policy#:_____ Group#:_____

Name of Policy Holder: _____ Date of Birth:_____ Relation: _____

Secondary Insurance: Name/Policy #/Group#_____

If patient is under 18 or a legal dependent, please complete back of this form

<u>Emergency Contact:</u>

Name: _____ Relation to Patient: _____ Phone#_____

If Workman's Comp or No Fault, date of incident: _____

The Information is accurate and complete to the best of my knowledge.

Patient Signature: _____ Print Name:_____ Date/Time:_____

Guarantor Information: Please complete if patient is under 18 or Legal Dependent

Name: _____ Relation: _____ Date of Birth: _____

Address: _____ Apt#:_____

City: _____ State: _____ Zip Code: _____

Email Address: _____

Home #:_____ Cell#:_____ Work#:_____