REGISTRATION

PHELPS PROFESSIONAL SERVICES

LOCATION OF SERVICE: ____________________

PHELPS

Phelps Memorial Hospital Center

701 N. Broadway . Sleepy Hollow, NY 10591 . 914-366-3000

PATIENT INFORMATION:

Name: ____________________

Street: ____________________ Apt# ________

City: ____________________

State: ____________ Zip Code: ____________

Home Phone #: ____________________

Cell Phone #: ____________________

Email Address: ____________________

Marital Status:

❒ Married ❒ Single ❒ Widowed

❒ Divorced ❒ Separated ❒ Life Partner

Sex: ❒ Male ❒ Female

Date of birth: ____________________

Social Security # : ____________________

Race:

❒ American Indian/Alaskan Native ❒ Black/African American ❒ White ❒ Other ❒ Unknown

Ethnicity:

❒ Hispanic ❒ Non-Hispanic ❒ Unknown

Prreferred Language: ____________________

Employer: ____________________

Street: ____________________

City: ____________________

State: ____________ Zip Code: ____________

RESPONSIBLE PARTY:

❒ Same as PATIENT ❒ Other:

Name: ____________________

Street: ____________________ Apt# ________

City: ____________________

State: ____________ Zip Code: ____________

Home Phone #: ____________ Other #: ____________

PRIMARY PHYSICIAN:

Name: ____________________

Phone #: ____________________

REFERRING/ATTENDING PHYSICIAN:

Name: ____________________

Phone #: ____________________

EMERGENCY CONTACT:

Name: ____________________

Phone #: ____________ Other #: ____________

Relationship to Patient:

INSURANCE INFORMATION:

Name of Insurance Co: ____________________

Street: ____________________

City: ____________________

State: ____________ Zip Code: ____________

Telephone: ____________________

Policy # (ID#): ____________________

Subscriber's name: ____________________

Patient's relationship to subscriber: ____________________

Group #: ____________________

Effective date: ____________________

Subscriber's date of birth: ____________________

If Workman's Comp or No Fault, date of accident: ____________________

SECONDARY INSURANCE (IF ANY):

Name of Insurance Co: ____________________

Street: ____________________

City: ____________________

State: ____________ Zip Code: ____________

Telephone: ____________________

Policy # (ID#): ____________________

Subscriber's name: ____________________

Patient's relationship to subscriber: ____________________

Subscriber's date of birth: ____________________

Group #: ____________________

Effective date: ____________________

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

PREFERRED PHARMACY

Pharmacy Name: ____________________

Pharmacy Phone #: ____________________

Pharmacy Address: ____________________