EAST NORTHPORT MEDICAL CARE

PATIENT REGISTRATION INFORMATION

LAST NAME:_______________________________________ FIRST:____________________________

ADDRESS:____ APT #__________________

CITY:____STATE:_________ZIP:_______

SS#___________ _________ ___________

HOME#:________________________________ WORK#:________________________EXT:_________

CELL#:_________________________________ OTHER #:____________________________________

DATE OF BIRTH:____________ AGE:_____ SEX:______MARITAL STATUS:___________________

EMPLOYER:__________________________________OCCUPATION:___________________________

EMERGENCY CONTACT NAME:_____________________________PHONE#____________________

***PRIMARY INSURANCE*: ALL INFORMATION MUST BE COMPLETE!!!!!!**

INSURANCE COMPANY NAME:____

ADDRESS:_________________________________CITY:___________________STATE:____ZIP_____

ID#/POLICY#:_______________________________________GROUP#__________________________

POLICY HOLDERS NAME:___________________________ **RELATIONSHIP:**____________________

POLICY HOLDERS DOB:_______________________ AND SS#:________________________________

***SECONDARY INSURANCE*: ALL INFORMATION MUST BE COMPLETE!!!**

INSURANCE COMPANY NAME:____

ADDRESS:________________________________ CITY:____________________STATE:____ZIP_____

ID#/POLICY#:_______________________________________GROUP#___________________________

POLICY HOLDERS NAME:___________________________ RELATIONSHIP:____________________

POLICY HOLDERS DOB:_______________________ AND SS#:________________________________

I authorize payment of insurance benefits directly to East Northport Medical Care.
I authorize the release of any necessary medical information to all my insurance companies.
I understand that I will be held liable for payment of all services rendered to me by East Northport Medical Care if I have provided incorrect insurance information which results in non-payment on any date of service.
I understand that I am responsible for any unpaid portions of my deductible and/or coinsurances.
It is your responsibility to be aware of your insurance coverage, policy provisions, exclusions and limitations.
This information is furnished by your insurance carrier and every patient's policy is different. Our relationship is with you and not your insurance company but we will gladly provide you with any information you need for you to contact your insurance company to inquire about non covered services.
A $10.00 billing processing fee will be added to any copayments not paid on the day services are provided.
There will be a $35.00 fee for any check dishonored by any Financial Institution.
I permit a copy of this authorization to be used in place of the original.
I authorize the doctor to act as my agent in helping me obtain payment from my insurance company.
I acknowledge receiving a copy of ENMC privacy act. I acknowledge receipt of the Joint Notice of Privacy Practices from Beacon CHSLI.

DATE:_______________________________ PRINT NAME:____
Patient/Parent/Legal Guardian

SIGNATURE:____

PLEASE PROVIDE YOUR PHOTO ID AND INSURANCE CARD(S) TO THE RECEPTIONIST