



KIPS BAY ENDOSCOPY CENTER, LLC

PATIENT REGISTRATION

TODAY'S DATE \_\_\_\_\_ DOB \_\_\_\_\_ AGE \_\_\_\_\_

PATIENT'S NAME \_\_\_\_\_
(First Name) (MI) (Last Name)

ADDRESS \_\_\_\_\_
(Street) (Apt#) (City) (State) (Zip code)

HOME PHONE# \_\_\_\_\_ CELL PHONE \_\_\_\_\_ ALTERNATE PHONE# \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_ PHONE# \_\_\_\_\_ RELATION \_\_\_\_\_

SOCIAL SECURITY# \_\_\_\_\_ E-MAIL ADDRESS \_\_\_\_\_

MARITAL STATUS S M W D O SEX M F OCCUPATION \_\_\_\_\_

EMPLOYER \_\_\_\_\_ WORK PHONE# \_\_\_\_\_

ADDRESS \_\_\_\_\_
(Street) (City) (State) (Zip code)

SEND REPORT TO DR: \_\_\_\_\_ PHONE# \_\_\_\_\_ FAX# \_\_\_\_\_

ADDRESS \_\_\_\_\_ DO YOU HAVE A WRITTEN REFERRAL? \_\_\_\_\_

DO YOU HAVE ANY ALLERIGIES? [ ] YES [ ] NO

ALLERGIES TO MEDICATIONS? [Please indicate drug names] \_\_\_\_\_

ALLERGIES TO FOOD? [Please list all foods] \_\_\_\_\_

ALLERGY TO LATEX? [ ] YES [ ] NO

PRIMARY INSURANCE COMPANY NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE # \_\_\_\_\_

NAME OF INSURED \_\_\_\_\_ DOB \_\_\_\_\_ SS# \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

SECONDARY INSURANCE COMPANY NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE # \_\_\_\_\_

NAME OF INSURED \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

I, the undersigned, have insurance with \_\_\_\_\_ and assign benefits directly to the provider for all medical benefits, if any, otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions.

PATIENT'S SIGNATURE: \_\_\_\_\_

Do you have a Health Care Proxy [ ] No [ ] Yes. If Yes, type: \_\_\_\_\_ Copy provided? [ ] No [ ] Yes

Do you have a Living Will? [ ] No [ ] Yes. If Yes, type: \_\_\_\_\_ Copy provided? [ ] No [ ] Yes

By signing below I acknowledge receiving the Centers practices Notice of Privacy Practices and The Patients Bill of Rights and Responsibilities.

PATIENT'S SIGNATURE: \_\_\_\_\_

If an interpreter is necessary please sign below indicating the patient understands and agrees to the terms herein.

INTERPRETER'S SIGNATURE: \_\_\_\_\_