North Shore LIJ Lenox Hill Hospital

485 Madison Avenue
(between. 51st-52nd street)
21st floor
New York, NY 10022

**David B. Samadi, M.D.**
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Chairman of Urology,
Chief of Robotic Surgery at
Lenox Hill Hospital
Professor of Urology at
Hofstra North Shore-LIJ
School of Medicine

# Patient Registration Form

I am here to see Dr. ____________________

## Patient Information

| Patient Name (Last, First, Middle/Maiden Name) | Date | Driver's License Number<br>State: |
|---|---|---|

| Home Address | Apt./Lot | City | State/Zip |
|---|---|---|---|

| Mailing Address (if different from Home Address) | Apt./Lot | City | State/Zip |
|---|---|---|---|

| Date of Birth | Social Security # | Marital Status<br>☐ Married ☐ Single ☐ Divorced<br>☐ Widowed ☐ Separated | Sex<br>☐ Male<br>☐ Female |
|---|---|---|---|

| Best time/number to reach you? | Home Phone<br>( ) | Work Phone<br>( ) | Mobile Phone<br>( ) | Email |
|---|---|---|---|---|

| Employer/Company Name | Employer Mailing Address | City | State/Zip | Occupation |
|---|---|---|---|---|

| Parent/Spouse's Name | Parent/Spouse's SSN | Employer | Employer's Address | Employer's Phone # |
|---|---|---|---|---|

## Emergency Contact

| Name of Contact (not living at same address) | Phone<br>( ) |
|---|---|

| Address | City | State/Zip |
|---|---|---|

## Insurance Information

| Primary Carrier Insurance Company | Effective Date | Secondary Carrier Insurance Company | Effective Date |
|---|---|---|---|
| Insurance Carrier Mailing Address | City / State/Zip | Insurance Carrier Mailing Address | City / State/Zip |
| Policy Holder's Name | Employer of Policy Holder | Policy Holder's Name | Employer of Policy Holder |
| Policy #/Social Security # | Group # | Policy #/Social Security # | Group # |
| Relationship to Patient | Policy Holder's DOB | Relationship to Patient | Policy Holder's DOB |

## Responsible Party Information

If other than parent/spouse listed

| Head of Household or Parent with Custody of Minor | Relationship to Patient | Responsible Party's Social Security # |
|---|---|---|
| Mailing Address / Apt./Lot / City | | State/Zip |

| Employer/Employer Mailing Address | City | State/Zip | Occupation |
|---|---|---|---|

| Best time/number to reach you? | Home Phone ( ) | Work Phone ( ) | Mobile Phone ( ) | Email |
|---|---|---|---|---|

## Referring Physician Information

| Referring Physician | | Phone ( )<br>Fax ( ) |
|---|---|---|
| Address | City | State/Zip |
| Internist | | Phone ( )<br>Fax ( ) |
| Address | City | State/Zip |
| Cardiologist | | Phone ( )<br>Fax ( ) |
| Address | City | State/Zip |
| Pharmacy Name | | Phone ( )<br>Fax ( ) |

## Authorization for Treatment

I, the undersigned, certify that I (or my dependent) have insurance coverage as per the information provided by me on this form. I further request payment of authorized Medical Benefits to be made to the office of Dr. ________________________for any services furnished to me. I understand that I am financially responsible for all services, whether or not covered by my insurance.

I hereby authorize my provider to release all information acquired in the course of the medical examination and treatment for insurance claim filing. Photostat of this authorization shall be considered as effective and valid as the original.

______________________________ Patient/Legal Guardian Signature

______________ Date

______________________________ Patient/Legal Guardian (print)

**For Internal Use Only:**

- ☐ Demo Ck ________
- ☐ Policy # ________
- ☐ Ins Info ________
- ☐ SSN ________
- ☐ Snture ________
- ☐ Other ________