NEW YORK MEDICAL & SURGICAL
EYE CARE

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New York, NY 10016
Telephone: (212) 242-2200
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PATIENT REGISTRATION FORM

Patient Name: ____
First Name Middle Name Last Name

☐ Mrs. ☐ Mr. ☐ Miss ☐ Ms. ☐ Dr.

Date of Birth: ______________________________ Gender: ☐ M ☐ F

Social Security Number: ______________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Legally Separated

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American

☐ Native Hawaiian/Other Pacific Islander ☐ White ☐Unknown

☐ Decline to Answer

Ethnicity: ☐ Non-Hispanic/Latino ☐ Hispanic/Latino ☐ Decline to Answer

Primary Language: ☐ English ☐ Spanish ☐ Chinese ☐ Other_______________

Home Address: ____
Home Telephone Number:_______________________________________
Cell Phone Number: ____
I consent to be contacted via text messages for appointment reminders and/or general health reminders/ information: YES ☐ NO ☐

Email:____
Occupation: ____

Employer Name: ____
Employer Address: ____
Work Phone Number: ____

Pharmacy Name: ____
Pharmacy Phone Number: ____
Pharmacy Address: ____

Referring Physician Name: ____
Referring Physician Phone Number: ____
Referring Physician Address: ____

Primary Care Physician Name: ____
Primary Care Phone Number: ____
Primary Care Physician Address: ____

Optometrist Name: ____
Optometrist Address: ____
Optometrist Phone Number: ____

Emergency Contact Name: ____
Relationship to you: ____
Home Telephone Number: ____
Cell Phone Number: ____
Signature of Patient/Parent/Guardian:____

How did you find NYMSEC? ☐ Family ☐ Friend ☐ NYMSEC Website ☐ Insurance

Directory ☐ Close to Home/Work _______________________ ☐ Google Search

☐ PCP/Specialist________________________ ☐ Optometrist ________________________

☐ Other _________________________________
Other Family Members Seen at NYMSEC: ____

DESIGNATION OF PEOPLE TO YOUR HEALTHCARE INFORMATION

I agree that NYMSEC may disclose certain portions of my health information to a relative, friend and/or caregiver because such person is involved with my health care or payment relating to my health care. In that instance, NYMSEC will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my heath care.

☐ I Wish to Make a Designation at This Time

Signature of Patient/Parent/Guardian:____

I designate the following persons listed below as persons involved with my health care or payment relating to my health care for the purpose of NYMSEC's making limited disclosures described above. I understand that I am not required to list anyone. I also understand that I may change this list at any time in writing.

Name:__________________________________ Date of Birth: ______________________

Cell Phone Number:_____________________ Email:______________________________

Name:__________________________________ Date of Birth: ______________________

Cell Phone Number:_____________________ Email: ______________________________

PRIMARY INSURANCE INFORMATION

Is Patient Covered By Medical Insurance: ☐ YES ☐ NO

Name of Insured: ____

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____________

Insurance Name: ____

Insurance Plan: ____

Insured Policy/ID Number: ____

Group Policy Number: ____

If Insured is anyone other than self (patient), please provide the following information:

Insured Social Security Number: ____

Insured Date of Birth: ____

Insured Employer: ____

SECONDARY INSURANCE INFORMATION

Name of Insured: ____

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐Other__________

Insurance Name: ____

Insurance Plan: ____

Insured Policy/ID Number: ______________________________________

Group Policy Number: ____

If Insured is anyone other than self (patient), please provide the following information:

Insured Social Security Number: _________________________________

Insured Date of Birth: ____

Insured Employer: ____

WORKER'S COMPENSATION INFORMATION

Is This a Worker's Comp: ☐ YES ☐ NO

If Yes, Date of accident: ___________________ Employer Notified: ☐ YES ☐ NO

Time of Accident:__________Location of Accident: _________________________

Worker's Compensation Board (WCB) Case Number: ____________________

Worker's Compensation Carrier Information: _________________________

Insurance Policy Number: _______________________________________

RESPONSIBLE PARTY/ GUARANTOR INFORMATION

Person Responsible To Pay Bills:_________________________________

If Responsible Party/Guarantor is anyone other than patient, please provide the following information:

Address:____

Date of Birth: ____

Social Security Number: _______________________________________

Home Telephone Number: _______________________________________

Cell Phone Number: ____

Email: ____

Occupation:____

Employer Name: ____

Employer Address: ____

Work Phone Number: ____

PATIENT ACKNOWLEDGMENT & FINANCIAL RESPONSIBILITY

The information provided by me in the Patient Registration Form is accurate and true to the best of my knowledge._______**(INITIAL)**

I understand that I need to present my insurance card and a form of identification to all my visits with New York Medical & Surgical Eye Care. It is my responsibility to notify the office staff regarding any insurance coverage and participation changes. ________________**(INITIAL)**

I have received **The Notice of Privacy Practices** and have had an opportunity to review it and obtain a copy from the office or New York Medical & Surgical Eye Care's website for my records. _ **(INITIAL)**

Assignment of Benefits: I hereby assign medical and/or surgical benefits, to which I am entitled, including Medicare, private insurance and any other health and/or vision plan to New York Medical & Surgical Eye Care. A photocopy of this assignment is to be considered as valid as original. I hereby authorize New York Medical & Surgical Eye Care to release all information necessary to secure the payment._______**(INITIAL)**

Financial Responsibility: I understand that **I am financially responsible for all uncovered services that my insurance or New York Medical & Surgical Eye Care determines is my responsibility** (Refraction, Prescription Glasses, Deductibles, Co-insurance, Copays, etc.)._______**(INITIAL)**

Patient Name: ____

Patient Signature: ____

Date: ____________________________________

Guarantor Name: ____

Guarantor Signature: ____

Date: ____________________________________