NEW YORK MEDICAL & SURGICAL
EYE CARE

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New York, NY 10016
Telephone: (212) 242-2200
Fax: (212) 242-3003
Email: info@nyeyecare.com

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: _____