

PLEASE PRINT

REGISTRATION FORM

PATIENT INFORMATION			
Last Name:	First Name:	MI:	
Street address:			
Home Phone:	<input type="checkbox"/> Preferred	Cell Phone:	<input type="checkbox"/> Preferred
Work Phone:	<input type="checkbox"/> Preferred	Pat Birth Date:	Sex:
PCP:	<input type="checkbox"/> none	Referring Provider:	
Are you transferring care from another provider? YES NO		Name of Provider:	
Marital Status:			SSN:
Employer Name:		Address:	
Emergency Contact:		Relationship:	
Emergency Contact Home Phone:	Cell Phone:	Work Phone:	
Responsible Party:		Relationship:	
INSURANCE INFORMATION			
(Please present your photo ID and insurance card to the receptionist.)			
Primary Insurance Carrier:		Effective Date:	
Subscriber ID:		Co-pay/Coinsurance amount:	
Subscriber:		Subscriber Birthdate:	
Relationship to Insured:		<input type="checkbox"/> Self	
Insurance Address:		Insurance Phone:	
Secondary Insurance Carrier:		Effective Date:	
Subscriber ID:		Co-pay/Coinsurance amount:	
Subscriber:		<input type="checkbox"/> Self	
Relationship to Insured:		Group Number:	
Insurance Address:		Insurance Phone:	
GENERAL INFORMATION			
OK to leave messages at home : YES NO		OK to leave messages on cell : YES NO	
OK to leave messages at work : YES NO		Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown <input type="checkbox"/> Decline	
Primary Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish		Other (specify):	
Race: <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Other Race <input type="checkbox"/> Decline			
Consent to report immunizations to NYSIIS (New York State Immunization Information System): SEE NYS CONSENT FORM			
Pharmacy:	City:	Phone:	
Pharmacy:	City:	Phone:	
How did you hear about our offices: <input type="checkbox"/> Brochure <input type="checkbox"/> Internet <input type="checkbox"/> Newspaper <input type="checkbox"/> Phonebook <input type="checkbox"/> Radio <input type="checkbox"/> Physician: Name <input type="checkbox"/> Family Member: Name			
ACKNOWLEDGEMENT/AUTHORIZATION			INITIAL
I give consent to the physician to provide and perform such medical and/or surgical care, test, procedure, prescriptions, and other services and supplies that are deemed necessary or beneficial by my physician for my health and well being			
The above information is true to the best of my knowledge.			
I authorize Health Quest Medical Practice/Health Quest Immediate Care Center to release medical information required to process my claims.			
I authorize my insurance benefits (Medicare, Medicaid, Commercial, etc...) be paid directly to the physician.			
A copy of our Notice of Privacy Practices has been made available to me.			
Patient/Guardian Signature :		Date :	