FAMILY HEALTH CENTERS AT NYU LANGONE

Patient Registration **(Please Print, Complete as much as Possible)**

Name: Mailing Address:

In Care Of: Home Phone: Cell:

Date of Birth: Place of Birth: Race:

SSN: E-Mail Address:

Gender: Gender Identification: Marital Status:

Language (If Interpreter Needed): Employed?: ( )Yes ( )No ( )Full/T ( )Part/T

Employer Name: Employer Address:

Employer Phone: Occupation: Pharmacy:

Family Size: **Annual Gross Household Income: $**

RELATIVE INFORMATION/EMERGENCY CONTACT

Name: Address:

Home Phone: Cell Phone:

Relation:

GUARANTOR INFORMATION

Name: Address:

Date of Birth: Gender: Home Phone: Cell:

E-Mail: SSN: Employed?: ( )Yes ( )No ( )Full/T: ( )Part/T:

Employer Name: Employer Address:

Phone: Occupation:

INSURANCE INFORMATION (Primary)

Insurance Carrier Name: Address:

Phone Number: Insured Name:

Date of Birth: Gender: SSN:

Relationship to Patient: Policy/ID Number:

Group Number: Copay( )Y ( )N Amt: Insurance Eff Date: Exp Date:

INSURANCE INFORMATION (Secondary)

Insurance Carrier Name: Address:

Phone Number: Insured Name:

Date of Birth: Gender:

SSN: Relation to Patient:

Policy/ID Number: Group #:

Copay Y: N: Amt: Insurance Eff Date: Exp Date:

**Advance Directive Info Given (Adult Patients Only) ( ) Yes ( ) No

Calls re: your care will be made to your home phone unless you indicate differently

☐ Cell ☐ Text ☐ E-mail

MR# Account #

Pt. Type Service

Admit Date Admit Time

Admit Diagnosis

Admit Physician

Attend Physician PCP