Patient Registration

NYOG

Patient Name:_____ Date of Birth: ___/___/___ Age: _____

Home Address:_____ Home Phone: (___)_____

City/State/Zip:_____ Work Phone: (___)_____

S.S.#_____ Sex:_____ Cell Phone: (___)_____

Occupation:_____ E-mail Address:_____

Employer:_____ Employer Address:_____

_____ _____

Insurance Information

Primary:_____	Secondary:_____
Policy Holder:_____	Policy Holder:_____
Policy #:_____	Policy #:_____
Insured ID:_____	Insured ID:_____
Insured DOB:_____	Insured DOB:_____

Referred by:_____

Reason for the visit:_____

I understand that I am financially responsible for all fees for services rendered to me including the balance remaining after the possible insurance benefits. I hereby authorize the direct payment of services rendered to me and authorize release of medical information necessary to pay the claim. I permit a copy of this authorization to be used in place of the original.

Signature:_____ Date:_____

Patient ð Guardian ð

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to New York Otolaryngology Group for services furnished to me by the provider. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services

Patient's Signature:_____ Date:_____