MOUNT SINAI
SCHOOL OF
MEDICINE

Patient Registration Form

Mount Sinai Medical Center
Department of Urology

I am here to see Dr. ______________________

Patient Information

Patient Name (Last, First, Middle/Maiden Name)				Date	Driver's License Number State:
Home Address	Apt./Lot	City			State/Zip
Mailing Address (if different from Home Address)	Apt./Lot	City			State/Zip

Date of Birth	Social Security #	Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated	Sex ☐ Male ☐ Female

Best time/number to reach you?	Home Phone ( )	Work Phone ( )	Mobile Phone ( )	Email

Employer/Company Name	Employer Mailing Address	City	State/Zip	Occupation
Parent/Spouse's Name	Parent/Spouse's SSN	Employer	Employer's Address	Employer's Phone #

Emergency Contact

Name of Contact (not living at same address)		Phone ( )
Address	City	State/Zip

Insurance Information

Primary Carrier Insurance Company	Effective Date		Secondary Carrier Insurance Company	Effective Date	
Insurance Carrier Mailing Address	City	State/Zip	Insurance Carrier Mailing Address	City	State/Zip
Policy Holder's Name	Employer of Policy Holder		Policy Holder's Name	Employer of Policy Holder	
Policy #/Social Security #	Group #		Policy #/Social Security #	Group #	
Relationship to Patient	Policy Holder's DOB		Relationship to Patient	Policy Holder's DOB	

Responsible Party Information

If other than parent/spouse listed

Head of Household or Parent with Custody of Minor	Relationship to Patient	Responsible Party's Social Security #

Mailing Address	Apt./Lot	City	State/Zip

Employer/Employer Mailing Address	City	State/Zip	Occupation

Best time/number to reach you?	Home Phone	Work Phone	Mobile Phone	Email
	( )	( )	( )	

Referring Physician Information

Referring Physician	Phone ( ) Fax ( )
Address / City	State/Zip
Internist	Phone ( ) Fax ( )
Address / City	State/Zip
Cardiologist	Phone ( ) Fax ( )
Address / City	State/Zip
Pharmacy Name	Phone ( ) Fax ( )

Authorization for Treatment

I, the undersigned, certify that I (or my dependent) have insurance coverage as per the information provided by me on this form. I further request payment of authorized Medical Benefits to be made to the office of Dr. ________________________for any services furnished to me. I understand that I am financially responsible for all services, whether or not covered by my insurance.

I hereby authorize my provider to release all information acquired in the course of the medical examination and treatment for insurance claim filing. Photostat of this authorization shall be considered as effective and valid as the original.

______________________________ ______________

Patient/Legal Guardian Signature Date

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Patient/Legal Guardian (print)

For Internal Use Only:

☐ Demo Ck ________ ☐ Ins Info ________ ☐ Snture ________

☐ Policy # ________ ☐ SSN ________ ☐ Other ________