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BRONX, NY 10469
P (718) 654-7122
F (718) 547-5876

CONFIDENTIAL PATIENT REGISTRATION FORM

NAME: _____ DATE OF BIRTH: _____
PREFERRED LANGUAGE: _____ SOCIAL SECURITY: _____
HOME ADDRESS: _____
CITY, STATE, ZIP CODE: _____
PHONE NUMBER: _____ EMAIL:_____

EMERGENCY CONTACT NAME: _____
RELATIONSHIP: _____ PHONE NUMBER: _____
ADDRESS: _____

PRIMARY DOCTOR: _____
PHONE NUMBER: _____
ADDRESS: _____

PHARMACY: _____
PHONE NUMBER: _____
ADDRESS: _____

<u>DEMOGRAPHIC INFORMATION (FOR HEALTH CARE QUALITY MEASURES)</u>

SEX: ○M ○F MARITAL STATUS: ○S ○M ○D ○W HISPANIC/LATINO: ○YES ○NO
RACE: ○WHITE ○BLACK ○INDIAN/ALASKAN ○ASIAN ○PACIFIC ISLANDER ○DECLINED
SMOKING STATUS: ○DAILY ○SOME DAYS ○FORMER SMOKER ○NEVER SMOKED

PRIMARY INSURANCE _____INSURED ID NUMBER: _____
SECONDARY INSURANCE: _____INSURED ID NUMBER: _____