CENTRAL PARK MEDICAL ASSOCIATES

200 Central Park South ■ Suite 107■ New York, NY 10019 ■ Corner of 7th Ave & 59 St. ■ 212.262.2500

Patient Registration Form

PLEASE READ THE IMPORTANT INFORMATION AT THE BOTTOM OF THIS FORM BEFORE RETURNING IT TO THE FRONT DESK

Name: _____ Gender: M / F

Address:_____ Apt#:_____

City/State:_____Zip:_____

Cell Telephone:_____ Home Telephone _____

Occupation:_____ Work Telephone _____ext____

Date of Birth:_____ Marital Status:_____ Email:_____

INSURANCE IDENTIFICATION #	INSURANCE NAME	SOCIAL SECURITY #
_____	_____	_____

How did you hear about our office? _____

What is your chief complaint or reason for today's visit?:

_____

Are you currently taking any medication? Do you have any drug allergies? Please list below:

_____

Medical history: If you need additional room, please notify the front desk.

_____

Select a Pharmacy: Please enter the code associated with your pharmacy.

_____

PAYMENT: I authorize payment directly to Advanced Dermatology Associates on my behalf for services rendered by them. I also authorize them to release any information needed to determine these benefits. I understand that I am responsible for payment of their services in full if payment is not made by the insurance company or union or if a referral is not obtained by me prior to services rendered.

Date _____ **Signature X**_____

UNIFORM ASSIGNMENT AND RELEASE OF INFORMATION STATEMENT

Authorization for release of information by_____

I hereby authorize the above named medical facility, having treated me, to release to governmental agencies, insurance carriers, or others who are financially liable for my medical care, and to permit representatives hereof to examine and make copies of all records relating to such care and treatment.

Date _____ **X**_____

Signature of Patient or Authorized Representative