Mel Kaplan, M.D.
Christopher Eten, MPAS, RPA-C
232 Fourth Avenue • Greenport, New York 11944 • 631-477-0070

PATIENT INSURANCE REGISTRATION FORM

PATIENT'S NAME _____ SOCIAL SECURITY # _____
(Last, First, Middle Initial)

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE (Home) _____ PHONE (Daytime) _____ PHONE (Cell) _____

EMAIL: _____ DATE OF BIRTH _____ SEX (circle): MALE FEMALE MARITAL STATUS (circle): S / M / D / W

*THE FOLLOWING MUST BE INDICATED SINCE THEY ARE GOVERNMENT MANDATED QUESTIONS

*RACE (circle): AMERICAN INDIAN/ALASKA NATIVE ASIAN BLACK/AFRICAN AMERICAN NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER WHITE

*ETHNICITY (circle): HISPANIC NON-HISPANIC PREFERRED LANGUAGE:

PRIMARY CARE PHYSICIAN NAME: _____ PHONE# _____
(as stated on insurance card if applicable)

EMPLOYER NAME: _____ EMPLOYER PHONE: _____

EMPLOYER ADDRESS _____ CITY _____ STATE _____ ZIP _____

SPOUSE'S NAME _____ SPOUSE'S PHONE _____ SPOUSE'S DATE OF BIRTH _____

SPOUSE'S ADDRESS _____ CITY _____ STATE _____ ZIP _____

RESPONSIBLE PARTY INFORMATION (circle) SELF SPOUSE CHILD PARENT STUDENT OTHER IF NOT SELF, COMPLETE FIELDS BELOW:

NAME (Last, First) _____ TELEPHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

EMERGENCY CONTACT: _____ PHONE: _____ CELL: _____

RELATIONSHIP TO PATIENT _____ ADDRESS OF CONTACT _____

INSURANCE INFORMATION (Please write information about the patient's insurance here.)

PRIMARY INSURANCE CO. NAME _____ SECONDARY INSURANCE CO. NAME _____

INSURED'S ID NO. _____ INSURED'S ID NO. _____

GROUP PLAN NO. _____ GROUP PLAN NO. _____

INSURANCE CO. ADDRESS _____ INSURANCE CO. ADDRESS _____

RELATIONSHIP TO INSURED _____ RELATIONSHIP TO INSURED _____

NAME OF INSURED _____ NAME OF INSURED _____

ADDRESS OF INSURED _____ ADDRESS OF INSURED _____

D.O.B. OF INSURED _____ SEX OF INSURED _____ D.O.B. OF INSURED _____ SEX OF INSURED _____

PHARMACY NAME: _____ ADDRESS _____

PHONE NUMBER: _____ PHARMACY FAX: _____

HOW WERE YOU REFERRED TO OUR OFFICE?(circle):SELF/ANOTHER PATIENT/WINTHROP EMERGENCY ROOM/EMPLOYER/DOCTOR/OTHER (please explain)

IF REFERRED BY OTHER, PLEASE EXPLAIN: _____

IF REFERRED BY A DOCTOR; PHYSICIAN NAME: _____ PHONE# _____

IF CLAIM IS NO FAULT OR WORKERS COMPENSATION PLEASE NOTIFY THE RECEPTIONIST FOR THE APPROPRIATE FORMS...

DID INJURY OCCUR AT SCHOOL? (circle):YES NO WAS INJURY DURING A SCHOOL SPORT(circle):YES NO NAME OF SPORT: _____
DATE OF INJURY: _____ SCHOOL NAME: _____ SCHOOL PHONE#: _____
SCHOOL INSURANCE CARRIER NAME: _____
SCHOOL INSURANCE ADDRESS: _____ CITY, STATE & ZIP: _____

X _____ _____