Patient Registration Information

Name: _____ Date of Birth: _____ Gender: _____

Preferred Name/Nickname: _____ Social Security Number: _____

Home Address: _____ City: _____ State/Zip: _____

Where May We Contact You: ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Other (please specify): _____

Home Phone: _____ Cell Phone: _____ Other: _____

E-mail Address: _____ *(Providing your e-mail will allow us to invite you to use IQHealth, our secure online patient portal)*

Marital Status: _____Spouse's Name: _____ Phone: _____

Is your spouse currently employed? ☐ Yes ☐ No Spouse's Employer: _____ Phone: _____

If spouse is the insured/responsible party: Spouse's Social Security Number: _____ Date of Birth: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Are you currently employed? ☐ Yes (please fill in information below) ☐ No

Employer Name: _____ Occupation: _____ Phone: _____

Employer Address: _____ City: _____ State/Zip: _____

Who is responsible for this bill: ☐ Self ☐ Spouse ☐ Other (please fill in information below)

Name: _____ Relationship: _____ Phone: _____

Address: _____ City: _____ State/Zip: _____

Social Security Number: _____ Date of Birth: _____ Secondary Phone: _____

Primary Insurance Information Are you covered by an employer or union health plan? ☐ Yes ☐ No

Insurance Company: _____ ID #: _____ Group: _____

Address: _____ City/State/Zip: _____ Phone: _____

Insured Name: _____ Relationship to Patient: _____Date of Birth: _____

Secondary Insurance Company: _____ ID #: _____ Group: _____

Address: _____ City/State/Zip: _____ Phone: _____

Insured Name: _____ Relationship to Patient: _____Date of Birth: _____

Primary Care Provider: _____ Phone: _____ City/State: _____

Referring Doctor (if different): _____ Phone: _____ City/State: _____

Chief Complaint/Symptoms Today: _____

Did you sustain an injury while at work? ☐ Yes ☐ No Are your injuries accident related? ☐ Yes ☐ No

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I certify that all information I have supplied on this form is true and correct to the best of my knowledge. I will notify Long Island Surgery of any changes in my status or information.

_____ _____

Signature of Patient or Authorized Party Date

_____ _____

Printed Name of Patient or Authorized Party Relationship to Patient