MIDDLE COUNTRY ENDOCRINOLOGY, P.C.

Patient Registration **(PLEASE PRINT CLEARLY!)**

Last Name:_____ **First Name**_____ **Date of Birth** _____

Social Security#:_____ __**Male**__ **Female** __**Single** __**Married** __**Other**_____

Street Address :_____ **City/State/Zip Code**: _____

Email Address: _____

Home Phone:_____ **Cell Phone**:_____ **Work Phone**:_____

Primary Language:_____ ***** **Ethnicity(circle one): Hispanic / Non- Hispanic / Deferred**

****** **Race (circle one): Caucasian / Asian / African American / American Indian / Deferred**

Mailing Address (if different than above): _____

Patient's Employer and Address: _____

_____

If patient is a Minor, Responsible party is: _____ **Relationship:** _____

In case of emergency, contact (not living with you):_____

Phone Number: _____**Relationship to Patient**:_____

REFERRING/PRIMARY CARE DOCTOR'S NAME:_____

ADDRESS AND PHONE:_____

PHARMACY NAME AND PHONE NUMBER: _____

*****PLEASE PRESENT INSURANCE CARD(S) FOR COPYING AND COMPLETE THE REQUESTED INFORMATION*****

PRIMARY INSURANCE:_____ **Phone Number**:_____

****Policy Holder's Name**: _____ ****Date of Birth**:_____

Policy #:_____**Group #**:_____ **Relation to patient:**_____

Policy Holder's Employer:_____ **Policy Holder's SS#:**_____

SECONDARY INSURANCE:_____ **Phone Number**:_____

****Policy Holder's Name**: _____ ****Date of Birth**:_____

Policy #:_____ **Group #:**_____ **Relation to patient:**_____

Policy Holder's Employer:_____ **Policy Holder's SS#:**_____

- **I hereby authorize the payment of medical benefits to Middle Country Endocrinology, PC for services rendered. I understand that I am financially responsible for any services not covered by my insurance carrier.**
- **I hereby authorize Middle Country Endocrinology, PC to release any medical information necessary to complete and process my insurance claims.**

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Patient's OR Insured's Signature (If patient is a Minor, must have Responsible Party Signature) Date