

# LIVING WELL MEDICAL, P.C

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Telephone: (212) 645-8151 Fax: (212) 777-1653

## PATIENT REGISTRATION FORM

For Office Use Only: WC  NF  PPO  HMO  MCR  COM  Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

### GENERAL INFORMATION

Patient's Name: \_\_\_\_\_  
Last Name First Name Middle I

Street: \_\_\_\_\_ Apt. \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Ph # ( ) \_\_\_\_\_ Work Ph# ( ) \_\_\_\_\_ Cell# \_\_\_\_\_

Date of Birth: MM: \_\_\_\_\_ DD: \_\_\_\_\_ YYYY \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  Female  Male

Social Security # : \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Marital Status:  Married  Divorced  Single

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Spouse/Guarantor's Name: \_\_\_\_\_ Employer: \_\_\_\_\_

Spouse/Guarantor's Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Work Phone #: ( ) \_\_\_\_\_

Spouse/Guarantor's Date of Birth: MM: \_\_\_\_\_ DD: \_\_\_\_\_ YYYY \_\_\_\_\_

Employer's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Closest Living Relative: \_\_\_\_\_ Tel.# ( ) \_\_\_\_\_ Cell# \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

### RESPONSIBLE PARTY INFORMATION

If Patient is a child, Name of Guarantor: \_\_\_\_\_

Street Address (if different than above): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

HOW WERE YOU REFERRED TO OUR OFFICE? Internet:  Search engine used: \_\_\_\_\_

Previously seen in our office:  Yes  No Referred by: \_\_\_\_\_

Referring Doctor's Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: ( ) \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Fax#: ( ) \_\_\_\_\_

Who is your General Medical Doctor: \_\_\_\_\_

Address : \_\_\_\_\_ Phone #: ( ) \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**INSURANCE INFORMATION**

Patient's Name: \_\_\_\_\_  
Last Name First Name Middle I

Primary Insurance Company: \_\_\_\_\_ ID/POLICY #: \_\_\_\_\_

Plan Name: \_\_\_\_\_ Group #: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Insured Name (if other than Patient): \_\_\_\_\_

Relationship to the insured:  Self  Spouse  Child

Secondary Insurance: \_\_\_\_\_ ID/Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured Name (if other than Patient): \_\_\_\_\_

Relationship to the insured:  Self  Spouse  Child

**WORKERS' COMPENSATION INFORMATION (If injured on the job or in the course of employment, please complete)**

Date of Accident: \_\_\_\_/\_\_\_\_/\_\_\_\_ Place of Accident: \_\_\_\_\_ State: \_\_\_\_\_

Employer at time of injury: \_\_\_\_\_ Phone #: ( ) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Carrier Case #: \_\_\_\_\_ WCB #: \_\_\_\_\_ Policy #: \_\_\_\_\_

Has a report been filed by your employer?:  Yes  No If yes, when? \_\_\_\_\_

**NO-FAULT (If injured in an auto accident or a pedestrian injured as a result of an auto accident, please complete)**

Date of Accident: \_\_\_\_/\_\_\_\_/\_\_\_\_ Place of Accident: \_\_\_\_\_ State: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Has a report been filed by your insurance company?:  Yes  No If yes, when? \_\_\_\_\_

Insured's Name (if other than Patient): \_\_\_\_\_

Policy #: \_\_\_\_\_ Claim #: \_\_\_\_\_

Comments (For office use only) \_\_\_\_\_

Attorney's name: \_\_\_\_\_ Phone #: ( ) \_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Initials \_\_\_\_\_

Input Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Office Use  
Office use only