COLON & RECTAL SURGICAL SPECIALISTS OF NEW YORK

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www.CRSSNY.com

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Locations in Nassau, Suffolk and Queens

PATIENT REGISTRATION

Who are you seeing today? Dr. Dean Pappas/Dr. Frank Caliendo/Dr. Steven Pelaez/Dr. Mala Balakumar/Dr. Jennifer Agnew/Dr. Cesar Sanz/Grace Halleran, PA

Last Name:_____ First:_____ MI:_____

Address:_____ City:_____State:_____ Zip:_____

Home #:_____-_____-_____Cell#_____-_____-_____Social Security#:_____-_____-_____

Place of Employment:_____ Work #:_____-_____-_____

What is your Date of Birth:_____/_____/_____ Age:_____

Circle One: Male/Female Marital Status: Single/Married/Divorced/Separated/Widowed

What is your E-mail Address?

_____@_____
Please check here if you don't have an e-mail address or don't want to disclose it._____

Who is your Family or Primary Care Physician?

Name:_____

Address:_____

Phone#:_____-_____-_____ Fax#:_____-_____-_____

Who may we thank for this referral?
Doctor/Friend/Family/Insurance Company/Internet/Other

If a Physician referred you, Who is the referring Physician:

Name:_____ Phone#:_____-_____-_____

Address:_____

Emergency Contact Information:

Name:_____Phone#:_____-_____-_____

Address:_____

What is your relationship to the above person?_____

Name:_____

Insurance Information

Does your insurance require a referral? Yes No
Do you have a referral today? Yes No

Primary Insurance Company:_____Policy#:_____

If insurance is under your spouse/parent for billing purposes, please provide:

Name:_____Date of Birth:_____/_____/_____SS#:_____/_____/_____

Secondary Insurance Co. Name:_____Policy#:_____

If under spouse/parent:_____Date of Birth:_____/_____/_____SS#:_____/_____/_____

Third Insurance Co. Name:_____Policy#:_____

If under spouse/parent:_____Date of Birth:_____/_____/_____SS#:_____/_____/_____

What is your Pharmacy Information?

Name:_____Phone#:_____-_____-_____

Address:_____

MEANINGFUL USE REQUIREMENT(government mandated)

Please Circle One:

Race: White, Hispanic, American Indian/Alaska Native, Asian, Black/African American, Native Hawaiian/Other Pacific Islander

Ethnicity: Hispanic/Non-Hispanic Preferred Language:_____

Social History –Please check ALL that apply:

Smoking Status: ( ) Never ( ) Former – When did you quit:_____
( )Current daily smoker – How many packs:_____
( )Current sometimes smoker- Explain:_____

Privacy Practices Acknowledgement:

I have Read/Received the notice of privacy practice and I have been provided an opportunity to review it. Due to the HIPPA Law, we are Not Allowed by Law to disclose any information pertaining to your medical condition, unless you authorize that information to be given.

INSURANCE ASSIGNMENT AND RELEASE:

I authorize the release of medical information necessary to process this claim and also authorize of medical benefits to the physician. I understand that it is my responsibility to present all insurance requirements to the office, i.e., insurance cards and referrals, and if I do not, I will be responsible for payment that day and will be reimbursed if I present such within 24 hours . By law, we must collect your carrier designated copay, deductible and co-insurance. Please be prepared to pay the copay at each visit. Should you not pay at the time of service and we subsequently send you a statement, a $10 charge will be added to your account. If there are reasons you cannot make your copay at each visit, arrangements MUST be made and approved in advance. Your signature below signifies your understanding and willingness to comply with this policy.

Patient Signature:_____**Date:**_____/_____/_____