NORTH SHORE-LONG ISLAND JEWISH HEALTH SYSTEM
Clinical Practice Plan

REGISTRATION FORM
Please Print Legibly

_____
CPP#

I. Patient Information

Patient Name_____ Sex_____M_____F Date of Birth_____/_____/_____

Social Security #_____-_____-_____ Marital Status_____ Home Telephone Number_____
S M W D

Address_____ _____ _____ _____
Street City State Zip

Father's First Name_____ Mother's First Name_____ Are you employed? ___Yes ___No
(If yes complete section *IV*)

Emergency Contact_____ Telephone Number_____ Relationship_____

II. Patient

Who referred you to our office? Name_____ Telephone Number_____
Last First

Address_____ _____ _____ _____
Street City State Zip

III. Primary Care Information:

Primary Physician Name)_____ Telephone Number_____
Last First

Address_____ _____ _____ _____
Street City State Zip

IV. Employer

Name of Employer_____Work Number_____Ext_____
Last First

Address_____ _____ _____ _____
Street City State Zip

V. Spouse Information

Spouses Name_____ Sex____M____F Date of Birth_____/_____/_____

Spouses Social Security #_____-_____-_____ Spouse Employed By_____

Spouses Employer Address_____ _____ _____ _____
Street City State Zip

INSURANCE INFORMATION

(Please provide insurance cards for verification)

VI. PRIMARY

Insurance Coverage_____ Relationship to Subscriber_____
Self, Spouse, Child, Student

Subscriber's Name_____ Subscriber's Date of Birth_____/_____/_____
Last First

Insurance ID Number_____Group Number_____Plan Number_____

Claims Address_____ _____ _____ _____
Street or P.O. Box City State Zip

VII. SECONDARY

Insurance Coverage_____ Relationship to Subscriber_____
Self, Spouse, Child, Student

Subscriber's Name_____ Subscriber's Date of Birth_____/_____/_____
Last First

Insurance ID Number_____Group Number_____Plan Number_____

Claims Address_____ _____ _____ _____
Street or P.O. Box City State Zip

Authorization for release of information by Clinical Practice Plan at NSLIJ Health System

I hereby authorize and direct the above named clinical practice, having treated me, to release to government agencies, insurance carriers, or others who are financially liable for my medical care, all information needed to substantiate payment for such medical care and to permit representatives thereof to examine and make copies of all records relating to such care and treatment.

VIII. _____ _____/_____/_____
Signature of Patient or Authorized Representative Date

I hereby assign, transfer, and set over to the above named clinical practice sufficient monies and/or benefits to which I may be entitled from governmental agencies, insurance carriers, or others who are financially liable for my medical care to cover the costs of the care and treatment rendered to myself or my dependent in said practice.

IX. _____ _____/_____/_____
Signature of Patient or Authorized Representative Date