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NEW YORK
SLEEP, SINUS & THYROID SURGERY CENTER

EDWARD J. SHIN M.D.

Patient Registration Form

Last Name:______ First Name:______ M.I.______

Address:______ City:______ State:______ Zip:______

Home Telephone:______ Work Telephone:______ SSN:______

Date of Birth:______ Age:______ Sex: M F Marital Status: S M LP D W

Primary Care Physician Name:______ Referring Physician's Name:______

Primary Care Physician Address:______ City:______ State:______ Zip:______

Referring Physician's Address:______ City:______ State:______ Zip:______

Primary Care Physician Telephone:______ Referring Physician's Telephone:______

Other Referral Source: Website:______ Other: Patient / Friend:______

Insurance Plan:______ Other:______

Employer's Name:______ Employer's Address:______

City:______ State:______ Zip:______ Type of Business:______

Spouse or Guardian Name:______ Relationship to Patient:______

Address:______ City:______ State:______ Zip:______

SSN:______ Date of Birth:______ Age:______ Spouse's Employer's Name:______

Employer's Address:______ City:______ State:______ Zip:______

Type of Business:______ Emergency Contact:______

Relationship:______ Emergency Telephone:______

Insurance Information: Please give us all pertinent information regarding your insurance coverage. If you have coverage by more then one carrier, supply information of both carriers. Please list all numbers on your card(s). Please check your insurance policy for a waiting period before coverage or pre-existing causes. IF YOUR COVERAGE IS CONTINGENT ON A SECOND OPINION OR PRE AUTHORIZATION APPROVAL, PLEASE BE SURE TO TELL US.

Primary Insurance Plan:______ Policy No.:______ Group No.:______

Insurance Company's Address:______ City:______ State:______ Zip:______

Policyholder's Name:______ Patient's Relationship to policyholder:______

Date of Birth of policyholder:______ Subscriber's SSN:______ Effective Date:______

Termination Date:______ Copay Amount:______ Secondary Insurance Plan:______

Policy No.:______ Insurance Company's Address:______ City:______

State:______ Zip:______ Policyholder's Name:______

Patient's Relationship to policyholder:______ Date of Birth of policyholder:______

Subscriber's SSN:______ Effective Date:______ Termination Date:______ Copay Amount:______

MY INSURANCE CARRIER(S):
I authorize the release of any medical information necessary to process my insurance claim(s) to Dr. Edward J. Shin, MD.
I authorize the request for payment of medical benefits directly to my physicians, Dr. Edward J. Shin, MD.
I agree that this authorization will cover all medical services rendered until such authorization is revoked by me.
I agree that all photocopies of this form may be used in lieu of the original.
I agree to pay all charges not covered by my insurance carrier(s): these charges include but are not limited to deductibles and co payments of my insurance policy.

Signature:______ Date:______