



FORM A - REGISTRATION

DATE OF SURGERY: _____ OB DUE DATE: _____ PHYSICIAN'S NAME: _____

100 East 77th Street, NY, NY 10075-1850 - Surgical Cases Fax to: **866-219-5545** / 210 East 64th Street, NY, NY 10065-7471 - Surgical Cases Fax to: **866-231-1027**

PATIENT INFORMATION
NAME - Last: _____ First: _____
ADDRESS - Street: _____ City: _____ Apt #: _____ State: _____ Zip: _____
COUNTY OF RESIDENCE: _____ PHONE: _____ Email _____
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RACE:
 Asian American Indian
 Black Native Hawaiian
 White Other _____
ETHNICITY:
 Hispanic / Latino Not-Hispanic Latino
Preferred Language: _____
GENDER: _____
MARITAL STATUS:
 Married Widowed
 Single Divorced
 Separated
DATE OF BIRTH:

MONTH DAY YEAR
MOTHER'S MAIDEN NAME: _____
PATIENT'S MAIDEN NAME: _____
PLACE OF BIRTH: _____
Are you an Employee of LHH / MEETH? Yes No
RELIGION: _____
ADVANCE DIRECTIVES:
 Yes (*Provide Copy*) No
Type: Healthcare Proxy
 Living Will
 Do Not Resuscitate
 Other: _____ SPECIFY _____
Do You Carry an Organ Donor's Card?
 Yes No
OCCUPATION: _____
EMPLOYER: _____
EMPLOYER ADDRESS- Street: _____
City: _____ State: _____ Zip: _____
Length of Service With Current Employer: _____
Years Months
EMPLOYER'S PHONE:
()
EMPLOYMENT STATUS: Employed Disabled
 Unemployed Retired

ACCIDENT INFORMATION - IF THIS ADMISSION IS THE RESULT OF AN ACCIDENT, PLEASE COMPLETE THIS SECTION IN FULL
TYPE OF ACCIDENT:
 Work Related Auto Home School Other
DATE OF ACCIDENT: _____
Month Day Year
TIME OF ACCIDENT: AM PM
LOCATION OF ACCIDENT: Street _____ City _____ State _____ Zip _____

PERSON RESPONSIBLE FOR FINANCIAL ARRANGEMENTS
NAME OF PERSON ON INSURANCE CARD: Last _____ First _____
RELATIONSHIP TO PATIENT: _____
NAME: Last _____ First _____
ADDRESS: Street _____ Apt # _____ City _____ Zip _____
COUNTY OF RESIDENCE: _____ **PHONE #:** _____ **Email** _____
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EMPLOYMENT STATUS:
 Employed Unemployed Disabled Retired
GENDER: _____ **BIRTH DATE:** _____
OCCUPATION: _____ **EMPLOYER:** _____
EMPLOYER ADDRESS: Street _____ City _____ State _____ Zip _____ **PHONE:** _____ Ext: _____
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PERSON TO CONTACT IN AN EMERGENCY
NAME: Last _____ First _____ **ADDRESS:** Street _____ City _____ Apt # _____ State _____ Zip _____
RELATIONSHIP TO PATIENT: _____ **HOME PHONE:** _____ **WORK PHONE:** _____ Ext: _____
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**IF PATIENT IS 18 OR UNDER (25 IF STUDENT) ENTER OTHER PARENT INFORMATION BELOW.
IF PATIENT IS MARRIED ENTER SPOUSE INFORMATION. OTHERWISE ENTER CLOSEST RELATIVE.**

LEGAL NEXT OF KIN
NAME: Last _____ First _____ **ADDRESS:** Street _____ City _____ Apt # _____ State _____ Zip _____
RELATIONSHIP TO PATIENT: _____ **DATE OF BIRTH:** _____ **HOME PHONE:** _____ **WORK PHONE:** _____ Ext: _____
() ()

MISCELLANEOUS Have you ever been an inpatient at Lenox Hill Hospital / MEETH? Yes No
If Yes, under what name? _____ **DATES:** From Mo Day Yr To Mo Day Yr
Have you ever been an inpatient in another Hospital or Skilled Nursing Facility within the last 60 days? Yes No
If Yes, under what name? _____ **DATES:** From Mo Day Yr To Mo Day Yr
Name of Institution: _____

DATE OF SURGERY:	PHYSICIAN'S NAME:
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INSURANCE INFORMATION PLEASE COMPLETE THE APPROPRIATE SECTIONS BELOW FOR BOTH PATIENT AND SPOUSE, OR BOTH PARENTS IF PATIENT IS 21 OR UNDER . . . **AND ATTACH A COPY OF BOTH SIDES OF THE INSURANCE CARDS.**

<p>MEDICARE</p> <p style="text-align: center;">MEDICARE HEALTH INSURANCE</p> <p style="text-align: center;">SOCIAL SECURITY ACT</p> <p>Name of Beneficiary _____</p> <p>Claim Number _____ Sex _____</p> <p>Is Entitles To _____ Effective Date _____</p> <p>Hospital (Part A) _____</p> <p>Hospital (Part B) _____</p> <p>MEDICARE PATIENTS OR SPOUSE:</p> <p>ARE YOU RETIRED? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>IS YOUR SPOUSE RETIRED? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>DATE OF RETIREMENT: Patient _____ Spouse _____</p>	<p>OTHER BLUE CROSS</p> <p>BLUE CROSS / BLUE SHIELD OF (State): _____</p> <p>SUBSCRIBER'S NAME: _____</p> <p>IDENTIFICATION: _____</p> <p>DO YOU HAVE OTHER INSURANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>IF SPOUSE IS EMPLOYED, PLEASE PROVIDE HIS/HER INSURANCE INFORMATION ON THIS FORM.</p>
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OTHER INSURANCE (HMO, UNION, TRAVELERS, METROPOLITAN, ETC.)

NAME ON CARD: Last _____ First _____	EMPLOYER NAME: <i>(As it appears on card)</i> _____
POLICY NUMBER: ID # _____ Group # _____	Address: _____
PAYOR ID NUMBER: _____	INSURANCE COMPANY NAME: _____
GROUP NAME: _____	Address: _____
	Phone: _____

WORKERS COMP (ATTACH AUTHORIZATION FORM)

INSURANCE COMPANY: NAME _____	ADDRESS _____	PHONE: () _____
EMPLOYER: NAME _____	ADDRESS _____	PHONE: () _____
WCB #: _____	ACCIDENT DATE: _____	ACCIDENT TIME: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM
		CLAIM FILED: <input type="checkbox"/> YES <input type="checkbox"/> NO

NO-FAULT (ATTACH FORM FROM INSURANCE COMPANY)

INSURANCE COMPANY: NAME _____	ADDRESS _____	PHONE: () _____
CAR OWNER: NAME _____	ADDRESS _____	PHONE: () _____
INSURANCE AGENT OR ATTORNEY: NAME _____		PHONE: () _____
ACCIDENT DATE: _____	ACCIDENT TIME: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM	POLICY NUMBER: _____
		FILE NO.: _____

MEDICAID

NAME ON CARD: LAST _____	FIRST _____
ID NUMBER: _____	
ISO #: _____	ACCESS NUMBER: _____
	SEQ. #: _____

SELF PAY / UNINSURED