North Shore LIJ Hospital	DATE OF SURGERY:	OB DUE DATE:	PHYSICI	FOF AN'S NAME:	- A M	REGIS	TRATION	
Snore LIJ Hospital								
100 East 77th Street, NY, NY 10075-1850 - Surgio	cal Cases Fax to: 866-2 1	19-5545 / 210 E	ast 64th Stre	eet, NY, NY 10065-	7471 - Surgic	al Cases Fax t	o: 866-231-1027	
PATIENT INFORMATION NAME - Last:			Firs	st:				
ADDRESS - Street:	City:			Apt #:	State:	Zip:		
COUNTY OF RESIDENCE:	PHONE:		Email					
RACE:	MOTHER'S MAI	MOTHER'S MAIDEN NAME:			Do You Carry an Organ Donor's Card? □ Yes □ No			
□ Black □ Native Hawaiian □ White □ Other	PATIENT'S MAI	TENT'S MAIDEN NAME:			OCCUPATION:			
ETHNICITY:	PLACE OF BIR	PLACE OF BIRTH:			EMPLOYER:			
Preferred Language:		Are you an Employee of			EMPLOYER ADDRESS- Street:			
	LHH / MEETH? RELIGION:			City:		State:	Zip:	
MARITAL STATUS: Married Widowed Single Divorced	ADVANCE DIRE	ECTIVES: $Copy$ \Box No		Length of Current E	Service With	Years	Months	
Separated DATE OF BIRTH:	Type: Health	ncare Proxy Will			ER'S PHONE	:		
	Other	ot Resuscitate	CIFY) MENT STATU	JS: Employ	red □ Disabled loyed □ Retired	
MONTH DAY YEAR ACCIDENT INFORMATION - IF THIS				NT. PLEASE CO	MPLETE T	-	-	
TYPE OF ACCIDENT:					ACCIDENT:			
□ Work Related □ Auto □ Home □ Sch				Month	Day		Year	
	ACCIDENT: Street		City		State	Zip		
PERSON RESPONSIBLE FOR FINA	ANCIAL ARKAN							
NAME OF PERSON ON INSURANCE CARD: Last	t	First		RELATION	ISHIP TO PAT	TIENT:		
NAME OF PERSON ON INSURANCE CARD: Last	t		Firs		ISHIP TO PAT	TIENT:		
	t Apt	First	Firs		ISHIP TO PAT	TIENT: Zip		
NAME: Last		First	Firs		ISHIP TO PA			
NAME: Last ADDRESS: Street COUNTY OF RESIDENCE: EMPLOYMENT STATUS:	Apt PHONE #: ()	First	Firs		ISHIP TO PA			
NAME: Last ADDRESS: Street COUNTY OF RESIDENCE:	Apt PHONE #: ()	First	Firs ity Email	t	ISHIP TO PA	Zip		
NAME: Last ADDRESS: Street COUNTY OF RESIDENCE: EMPLOYMENT STATUS: Demployed Disabled	Apt PHONE #: ()	First	Firs ity Email	t		Zip	Ext:	
NAME: Last ADDRESS: Street COUNTY OF RESIDENCE: EMPLOYMENT STATUS: Employed Unemployed Disabled OCCUPATION:	Apt	First t # Ci	Firs ty Email DYER:	GENDER:		Zip		
NAME: Last ADDRESS: Street COUNTY OF RESIDENCE: EMPLOYMENT STATUS: Employed Unemployed Disabled OCCUPATION: EMPLOYER ADDRESS: Street	Apt	First t # Ci	Firs ty Email OYER: Zip	GENDER:	Apt #	Zip		
NAME: Last ADDRESS: Street COUNTY OF RESIDENCE: EMPLOYMENT STATUS: Employed Unemployed Disabled OCCUPATION: EMPLOYER ADDRESS: Street PERSON TO CONTACT IN AN EM	Apt	First t # Ci EMPLO State	Firs ty Email OYER: Zip	t GENDER: PHONE: ()	Apt #	Zip BIRTH DATE	Ext:	
NAME: Last ADDRESS: Street COUNTY OF RESIDENCE: EMPLOYMENT STATUS: Employed Unemployed Disabled OCCUPATION: EMPLOYER ADDRESS: Street PERSON TO CONTACT IN AN EM NAME: Last First	Apt PHONE #: () Retired City ERGENCY HOME PHONE: () R UNDER (25 IF ST	First t # Ci EMPLO State ADDRESS: Street UDENT) ENTEF	Firs ty Email DYER: Zip	t GENDER: PHONE: (City WORK PI (PARENT INFOR	Apt # HONE:) MATION B	Zip BIRTH DATE: State ELOW.	Ext: Zip	
NAME: Last ADDRESS: Street COUNTY OF RESIDENCE: EMPLOYMENT STATUS: Employed Unemployed Disabled OCCUPATION: EMPLOYER ADDRESS: Street PERSON TO CONTACT IN AN EM NAME: Last First RELATIONSHIP TO PATIENT: IF PATIENT IS 18 OF	Apt PHONE #: () Retired City ERGENCY HOME PHONE: () R UNDER (25 IF ST	First t # Ci EMPLO State ADDRESS: Street UDENT) ENTEF	Firs ty Email OYER: Zip	t GENDER: PHONE: (City WORK PI (PARENT INFOR	Apt # HONE:) MATION B	Zip BIRTH DATE: State ELOW.	Ext: Zip	
NAME: Last ADDRESS: Street COUNTY OF RESIDENCE: EMPLOYMENT STATUS: Employed Unemployed Disabled OCCUPATION: EMPLOYER ADDRESS: Street PERSON TO CONTACT IN AN EM NAME: Last First RELATIONSHIP TO PATIENT: IF PATIENT IS 18 OR IF PATIENT IS 18 OR IF PATIENT IS MARRIE LEGAL NEXT OF KIN	Apt PHONE #: () Retired City ERGENCY HOME PHONE: () R UNDER (25 IF ST	First # Ci EMPLO State ADDRESS: Streed UDENT) ENTEF	Firs ty Email OYER: Zip	t GENDER: PHONE: (City City WORK PI (PARENT INFOR WISE ENTER C	Apt # HONE:) MATION B LOSEST R Apt #	Zip BIRTH DATE State ELOW. ELATIVE.	Ext: Zip Ext:	
NAME: Last ADDRESS: Street COUNTY OF RESIDENCE: EMPLOYMENT STATUS: Employed Unemployed Disabled OCCUPATION: EMPLOYER ADDRESS: Street PERSON TO CONTACT IN AN EM NAME: Last First RELATIONSHIP TO PATIENT: IF PATIENT IS 18 OF IF PATIENT IS 18 OF IF PATIENT IS 18 OF IF PATIENT IS MARRIE LEGAL NEXT OF KIN NAME: Last First RELATIONSHIP TO PATIENT:	Apt PHONE #: () Retired City ERGENCY HOME PHONE: () RUNDER (25 IF ST DENTER SPOUSE DATE OF BIRTH:	First # Ci EMPLO State ADDRESS: Streef UDENT) ENTEF INFORMATION ADDRESS: Streef HOME PHONE: ())	Firs ty Email OYER: Zip	t GENDER: PHONE: (City City VORK PI (PARENT INFOR VISE ENTER C City City (WORK PI ()	Apt # HONE:) MATION B LOSEST R Apt # HONE:)	Zip BIRTH DATE State ELOW. ELATIVE.	Ext: Zip Ext: Zip	
NAME: Last ADDRESS: Street COUNTY OF RESIDENCE: EMPLOYMENT STATUS: Employed Unemployed Disabled OCCUPATION: EMPLOYER ADDRESS: Street PERSON TO CONTACT IN AN EM NAME: Last First RELATIONSHIP TO PATIENT: IF PATIENT IS 18 OR IF PATIENT IS 18 OR IF PATIENT IS MARRIE LEGAL NEXT OF KIN NAME: Last First	Apt PHONE #: () Retired City ERGENCY HOME PHONE: () RUNDER (25 IF ST DENTER SPOUSE DATE OF BIRTH: Een an inpatient at I	First # Ci EMPLG State ADDRESS: Streef UDENT) ENTEF INFORMATIOI ADDRESS: Streef HOME PHONE: () Lenox Hill Hospi	Firs ty Email OYER: Zip	t GENDER: PHONE: (City City WORK PI (PARENT INFOR WISE ENTER C City City UNORK PI (H? □ Yes □ LATES:	Apt # HONE:) MATION B LOSEST R Apt # HONE:)	Zip BIRTH DATE: State ELOW. ELATIVE. State	Ext: Zip Ext: Zip	
NAME: Last ADDRESS: Street COUNTY OF RESIDENCE: EMPLOYMENT STATUS: Employed Unemployed Disabled OCCUPATION: EMPLOYER ADDRESS: Street PERSON TO CONTACT IN AN EM NAME: Last First RELATIONSHIP TO PATIENT: IF PATIENT IS 18 OR IF PATIENT IS MARRIE LEGAL NEXT OF KIN NAME: Last First RELATIONSHIP TO PATIENT: MISCELLANEOUS Have you ever be	Apt PHONE #: () Retired City ERGENCY HOME PHONE: () RUNDER (25 IF ST DENTER SPOUSE DATE OF BIRTH: Een an inpatient at I	First # Ci EMPLG State ADDRESS: Streef UDENT) ENTEF INFORMATIOI ADDRESS: Streef HOME PHONE: () Lenox Hill Hospi	Firs ty Email OYER: Zip R OTHER F N. OTHER	t GENDER: PHONE: (City City VORK PI (PARENT INFOR VISE ENTER C City City UNORK PI (H? □ Yes □ From	Apt # HONE:) MATION B LOSEST R Apt # HONE:) No No Mo Day	Zip BIRTH DATE: State ELOW. ELATIVE. State	Ext: Zip Ext: Zip Ext:	
NAME: Last ADDRESS: Street COUNTY OF RESIDENCE: EMPLOYMENT STATUS: Employed Unemployed Disabled OCCUPATION: EMPLOYER ADDRESS: Street PERSON TO CONTACT IN AN EM NAME: Last First RELATIONSHIP TO PATIENT: IF PATIENT IS 18 OR IF PATIENT IS MARRIE LEGAL NEXT OF KIN NAME: Last First RELATIONSHIP TO PATIENT: MISCELLANEOUS Have you ever be If Yes, under what name?	Apt PHONE #: () City ERGENCY HOME PHONE: () RUNDER (25 IF ST DATE OF BIRTH: DATE OF BIRTH: Een an inpatient at I Hospital or Skilled Nu	First # Ci EMPLO EMPLO State UDENT) ENTEF INFORMATIOI ADDRESS: Street HOME PHONE: () Lenox Hill Hospi ursing Facility wit	Firs ty Email OYER: Zip R OTHER F N. OTHER	t GENDER: PHONE: (City City VORK PI (PARENT INFOR VISE ENTER C City City UNORK PI (H? □ Yes □ From	Apt # HONE:) MATION B LOSEST R Apt # HONE:) No No Mo Day	Zip BIRTH DATE: State ELOW. ELATIVE. State	Ext: Zip Ext: Zip Ext:	

North Jenox I	Hill			FORM	ORM B - REGISTRATION			
North Shore LIJ Hospita		OF SURGERY: F	'HYSICIAN'S NAME:					
100 East 77th Street, NY, NY 10075-1850	- Surgical Cases	Fax to: 866-219-5545	/ 210 East 64th Street, NY, N	IY 10065-747	1 - Surgical Cases Fax to: 866-231-1027			
INSURANCE INFORMATION	PLEASE C	OMPLETE THE	APPROPRIATE SECTIO	NS BELO	W FOR BOTH PATIENT AND			
BOTH SIDES OF THE INSURA	SPOUSE, (NCE CARDS.	OR BOTH PAREN	TS IF PATIENT IS 21 OF	R UNDER	AND ATTACH A COPY OF			
MEDICARE			OTHER BLUE CROS					
MEDICARE	HEAL	TH INSURANCE						
SOCIAL SEC	URITY ACT		SUBSCRIBER'S NAME:					
Name of Beneficiary			IDENTIFICATION:					
Claim Number		Sex						
Is Entitles To	Effective Date	e						
Hospital (Part A)								
Hospital (Part B)								
MEDICARE PATIENTS OR SPOUSE	:		 DO YOU HAVE OTHER	INSURANC	E? 🗆 YES 🗆 NO			
ARE YOU RETIRED? YES NO IS YOUR SPOUSE RETIRED? YES NO			IF SPOUSE IS EMPLOY	IF SPOUSE IS EMPLOYED, PLEASE PROVIDE HIS/HER INSURANCE INFORMAITON ON THIS FORM.				
DATE OF RETIREMENT: Patient		Spouse						
OTHER INSURANCE (HMO, U	NION, TRAVEI	LERS, METROPOLII	AN, ETC.)					
NAME ON CARD: Last	First		EMPLOYER NAME: (As it appears on card)					
POLICY NUMBER: ID # Group #			Address:					
					Phone:			
PAYOR ID NUMBER:			INSURANCE COMPANY NAME:					
GROUP NAME:			Address:					
					Phone:			
INSURANCE COMPANY: NAME		ADDRESS			PHONE:			
EMPLOYER: NAME		ADDRESS			PHONE:			
					()			
WCB #:	ACCIDENT DATE		ACCIDENT TIME:	□ AM □ PM				
NO-FAULT (ATTACH	H FORM FROM	ADDRESS	PANY)		PHONE:			
INSURANCE COMPANY. NAME				()				
CAR OWNER: NAME ADDRESS				PHONE:				
INSURANCE AGENT OR ATTORNEY: NAME					() PHONE:			
					()			
ACCIDENT DATE:	ACCIDENT TIME:	□ AM □ PM			FILE NO.:			
MEDICAID								
NAME ON CARD: LAST			FIRST					
ID NUMBER:								
ISO #:	AC	CCESS NUMBER:		SEQ. #:				
ISO #:								