# REGISTRATION FORM

**Central Park Endocrinology PC**

**Dr. Gregory Dodell**

**Raya Galibov, PA** **Richard Neufeld MD** **Robert Romanoff MD. PC**

**PLEASE FAX COMPLETED DOCUMENTS TO 212-873-9311 OR EMAIL: office@cpenyc.com**

| | |
|---|---|
| **Today's Date**: | **PRIMARY MD NAME: IF YOU ARE BEING REFERRED**<br>**ADR:**<br>**TEL:** **FAX:** |

## PATIENT INFORMATION

| | | | | |
|---|---|---|---|---|
| **Last Name:** | **First:** | **Middle:** | **DOB:** | **M/F** |

**Address**: _____**APT NO**: _____

**CITY**:_____**STATE**:_____**ZIP**:_____

**PATIENT EMAIL ADR:**_____

**PHARM NAME:**_____**PHARM.TEL#**_____

| | | |
|---|---|---|
| **Social Security #** | **Home phone #:** | **Cell phone #:** |
| **Occupation:** | **Employer:** | **Employer phone #:** |

## INSURANCE INFORMATION

**(Please give your Insurance card and ID to the receptionist.)**

**PRIMARY INSURANCE**: NAME

| | | | | |
|---|---|---|---|---|
| **Subscriber's name:** | Subscriber's S.S. no.: | **Birth date**: | **POLICY #:** | **GROUP**: |

**Patient's relationship to subscriber:**

| | | |
|---|---|---|
| **SECONDARY INSURANCE**:<br>**NAME:**<br>**Subscriber's name**:<br>**Patient's relationship to subscriber:** | **Subscriber's Policy #/ Group #** | **Birth date:** |

## IN CASE OF EMERGENCY

| | | | |
|---|---|---|---|
| **Name of local friend or relative** | **Relationship to patient:** | **Home phone no.:** | **Work phone no.:** |

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims

**Signature** :_____ **Date**:_____