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## PATIENT REGISTRATION FORM

(Please Print)

| Name  | _   |   |  |         |  |
|---|---|---|--|---------|--|
| Address CityStateZip StateZip Patient Employed ByBirthdayBusiness Phone In case of emergency who should we notify? PRIMARY INSURANCE Person Responsible for Account   |   |   | Home Phone                                   |         |  |
| Address   | Last Name   |   | Soc. Sec. No                                 |         |  |
| Sex M F Age   | Address   |   |  |         |  |
| Patient Employed By   | City  |   | StateZip                                     |         |  |
| Business Address  | Sex 🗆 M 🗆 F Age   | Birthday  | 🗆 Single 🗌 Married 🗌 Widowed 🔲 Separated 🗌 🛛 | Divorce |  |
| n case of emergency who should we notify?   | Patient Employed By   |   | Occupation                                   |         |  |
| PRIMARY INSURANCE         Person Responsible for Account  | 3usiness Address  |   | Business Phone                               |         |  |
| Person Responsible for Account  | n case of emergency who should we r                                     | otify?  |  |         |  |
| Relation to Patient Birthdate Soc. Sec. No.     Address (if different from patient) Phone   Person Responsible Employed By Occupation Business Address ansurance Company Contract No. Contract No. Group No. Subscriber No. Subscriber No. State Site State Subscriber No. Subscriber No. Subscriber No. Subscriber No. Subscriber Name Relation to Patient Birthdate Subscriber Temployed By Soc. Sec. No. Subscriber Rame Relation to Patient Birthdate Subscriber Rame State State Zip State Zip Subscriber Employed By Soc. Sec. No. Soc. Sec. No. Soc. Sec. No. Soc. Sec. No. Subscriber Rame Soc. Sec. No. Subscriber Employed By Group No. Subscriber Rame Soc. Sec. No. Soc. Sec. No. Soc. Sec. No. Subscriber No. Subscriber Rame Soc. Sec. No. Soc. Sec. No. Soc. Sec. No. Subscriber No. Subscriber No. Subscriber Scoreed Under this Plan Soc. Sec. No. Subscriber No. Subscriber No. Subscriber No. Subscriber No. Subscriber No. Subscriber No. Soc. Sec. No. Soc. Sec. No. Soc. Sec. No. Subscriber No. Name of Other Dependents Covered Under this Plan ASSIGNMENT AND RELEASE Name of Insurance Company Name of Insurance Company Subscriber No. Name of Insurance Company Subscriber No. Subscriber N | ·   | PRIMARY II  | SURANCE                                      |         |  |
| Relation to Patient Birthdate Soc. Sec. No.     Address (if different from patient) Phone   Person Responsible Employed By Occupation Business Address ansurance Company Contract No. Contract No. Group No. Subscriber No. Subscriber No. State Site State Subscriber No. Subscriber No. Subscriber No. Subscriber No. Subscriber Name Relation to Patient Birthdate Subscriber Temployed By Soc. Sec. No. Subscriber Rame Relation to Patient Birthdate Subscriber Rame State State Zip State Zip Subscriber Employed By Soc. Sec. No. Soc. Sec. No. Soc. Sec. No. Soc. Sec. No. Subscriber Rame Soc. Sec. No. Subscriber Employed By Group No. Subscriber Rame Soc. Sec. No. Soc. Sec. No. Soc. Sec. No. Subscriber No. Subscriber Rame Soc. Sec. No. Soc. Sec. No. Soc. Sec. No. Subscriber No. Subscriber No. Subscriber Scoreed Under this Plan Soc. Sec. No. Subscriber No. Subscriber No. Subscriber No. Subscriber No. Subscriber No. Subscriber No. Soc. Sec. No. Soc. Sec. No. Soc. Sec. No. Subscriber No. Name of Other Dependents Covered Under this Plan ASSIGNMENT AND RELEASE Name of Insurance Company Name of Insurance Company Subscriber No. Name of Insurance Company Subscriber No. Subscriber N |   |   |  |         |  |
| Address (if different from patient) Phone   |   | Last Name   | First Name                                   |         |  |
| State   |   |   |  |         |  |
| Person Responsible Employed By Occupation<br>Business Address Business Phone<br>nsurance Company<br>Contract No Group No Subscriber No<br>Name of Other Dependents Covered Under this Plan<br>ADDITIONAL INSURANCE<br>s patient covered by additional insurance?<br>Subscriber Name Relation to Patient Birthdate<br>Address (if different from patient) Phone<br>City StateZip<br>Subscriber Employed By Business Phone<br>Subscriber Employed By Group NoSubscriber No<br>Contract No Group No Subscriber No<br>Name of Other Dependents Covered Under this Plan<br>Address [if undersigned certify that I (or my dependent) have insurance coverage with<br>Name of Insurance Company<br>Name of Insurance Company   |   |   |  |         |  |
| Business Address Business Phone<br>nsurance Company Group No Subscriber No<br>Name of Other Dependents Covered Under this Plan<br>ADDITIONAL INSURANCE<br>s patient covered by additional insurance? Yes No<br>Subscriber Name Relation to Patient Birthdate<br>Address (if different from patient) Phone<br>City State Zip<br>Subscriber Employed By Business Phone<br>nsurance Company Soc. Sec. No<br>Contract No Group No Subscriber No<br>Name of Other Dependents Covered Under this Plan<br>Address [If undersigned certify that I (or my dependent) have insurance coverage with<br>Name of Insurance Company   |   |   |  |         |  |
| Insurance Company Group NoSubscriber No<br>Name of Other Dependents Covered Under this Plan<br>ADDITIONAL INSURANCE<br>s patient covered by additional insurance?<br>Subscriber NameRelation to PatientBirthdate<br>Nume of different from patient)Relation to PatientBirthdate<br>CityStateZip<br>Subscriber Employed ByBusiness Phone<br>nsurance CompanySoc. Sec. No<br>Contract NoGroup NoSubscriber No<br>Name of Other Dependents Covered Under this Plan<br>ASSIGNMENT AND RELEASE   |   |   |  |         |  |
| Contract No Group No Subscriber No<br>Name of Other Dependents Covered Under this Plan<br>ADDITIONAL INSURANCE<br>s patient covered by additional insurance? Use No<br>Subscriber Name Relation to Patient Birthdate<br>Address (if different from patient) Relation to Patient Phone<br>City State Zip<br>Subscriber Employed By Business Phone<br>nsurance Company Soc. Sec. No<br>Contract No Group No Subscriber No<br>Name of Other Dependents Covered Under this Plan<br>ASSIGNMENT AND RELEASE   | Business Address  |   | Business Phone                               |         |  |
| Name of Other Dependents Covered Under this PlanADDITIONAL INSURANCE  s patient covered by additional insurance? Yes No Subscriber Name   | nsurance Company  |   |  |         |  |
| ADDITIONAL INSURANCE s patient covered by additional insurance? Yes No Subscriber Name  |   |   |  |         |  |
| s patient covered by additional insurance? Yes No Subscriber Name   |   |   |  |         |  |
| Subscriber Name   |   | ADDITIONAL  | INSURANCE                                    |         |  |
| Subscriber Name   | s natient covered by additional insurar                                 | nce? 🗌 Yes 🗌 No   |  |         |  |
| Address (if different from patient) Phone   | , ,   |   | ion to Patient Birthdate                     |         |  |
| CityStateZip<br>Subscriber Employed ByBusiness Phone<br>nsurance CompanySoc. Sec. No<br>Contract NoGroup NoSubscriber No<br>Name of Other Dependents Covered Under this Plan<br>ASSIGNMENT AND RELEASE  |   |   |  |         |  |
| Subscriber Employed By       Business Phone         nsurance Company       Soc. Sec. No         Contract No       Group No         Name of Other Dependents Covered Under this Plan       Subscriber No         ASSIGNMENT AND RELEASE       Assignment and the insurance coverage with         Name of Insurance Company       Name of Insurance Company   |   |   |  |         |  |
| nsurance Company Soc. Sec. No<br>Contract No Group No Subscriber No<br>Name of Other Dependents Covered Under this Plan<br>ASSIGNMENT AND RELEASE   |   |   |  |         |  |
| Contract No Group No Subscriber No<br>Name of Other Dependents Covered Under this Plan<br>ASSIGNMENT AND RELEASE<br>, the undersigned certify that I (or my dependent) have insurance coverage with<br>Name of Insurance Company  | Subscriber Employed By  |   |  |         |  |
| Name of Other Dependents Covered Under this Plan  |   |   | See See No                                   |         |  |
| ASSIGNMENT AND RELEASE , the undersigned certify that I (or my dependent) have insurance coverage with  | nsurance Company  |   |  |         |  |
| , the undersigned certify that I (or my dependent) have insurance coverage with   | nsurance Company  | Group No.   | Subscriber No.                               |         |  |
| , the undersigned certify that I (or my dependent) have insurance coverage with   | nsurance Company<br>Contract No<br>Name of Other Dependents Covered Un  | Group No  | Subscriber No                                |         |  |
| , the undersigned certify that I (or my dependent) have insurance coverage with   | nsurance Company<br>Contract No<br>Name of Other Dependents Covered Un  | Group No  | Subscriber No                                |         |  |
| and assign all insurance benefits to if any, otherwise payable to me for services rendered  | nsurance Company<br>Contract No<br>Name of Other Dependents Covered U   | Group No<br>nder this Plan<br>ASSIGNMENT                              | Subscriber No                                |         |  |
|   | Insurance Company<br>Contract No<br>Name of Other Dependents Covered Un | Group No nder this Plan ASSIGNMENT dependent) have insurance coverage | AND RELEASE with                             |         |  |