BETH ISRAEL MEDICAL CENTER - 258

NEW PATIENT REGISTRATION FORM

DATE	APPOINTMENT WITH	MR #

PATIENT INFORMATION

PATIENT'S LAST NAME/Apellido Del Paciente	FIRST NAME/Primer Nombre	DOB	AGE/Edad	SOCIAL SECURITY #

STREET ADDRESS/Direccion	APT. #	CITY/Ciudad	STATE	ZIP CODE	COUNTRY	SEX/Sexo (CIRCLE ONE) M F

HOME PHONE NO./Telephono	WORK PHONE NO.	MARITAL STATUS S M W D SP	SPOUSE'S NAME	SPOUSE'S WORK NO. EXT.
( )	( )			( )

PATIENT EMPLOYER/Patron Del Paciente'	F/T STUDENT Y N	ALLERGIES

EMPLOYER'S ADDRESS/Direccion Del Patron	CITY/Ciudad	STATE/Estado	ZIP CODE

EMERGENCY CONTACT PERSON/Contacto De Emergencia	RELATIONSHIP TO PATIENT	CONTACT'S HOME PHONE NO.	CONTACT'S WORK PHONE EXT.
		( )	( )

REFERRING MD NAME	ADDRESS	CITY	STATE	ZIP CODE	PHONE NO.
					( )

PRIMARY DOCTOR NAME	ADDRESS	CITY	STATE	ZIP CODE	PHONE NO.
					( )

GUARANTOR INFORMATION - Person responsible for payment, if other than self

GUARANTOR'S LAST NAME	FIRST NAME	RELATIONSHIP TO PATIENT	SOCIAL SECURITY	DOB	HOME PHONE NO.
					( )

GUARANTOR'S ADDRESS	APT. #	CITY	STATE	ZIP CODE	COUNTRY	SEX/Sexo (CIRCLE ONE) M F

GUARANTOR'S EMPLOYER	ADDRESS	CITY	STATE	ZIP CODE	WORK PHONE NO.
					( )

INSURANCE INFORMATION

MEDICARE	EFF. DATE	MEDICAID #	EFF. DATE

PRIMARY INSURANCE COMPANY	EFF. DATE	POLICY #	GROUP #	CERTIFICATE #

ADDRESS	CITY	ZIP CODE	STATE	ZIP CODE	PHONE NO.
					( )

NAME OF INSURED	PATIENT RELATIONSHIP TO INSURED	SOCIAL SECURITY #	DOB	SEX/Sexo (CIRCLE ONE) M F

INSURED'S ADDRESS	APT. #	CITY	STATE	ZIP CODE	COUNTRY	HOME PHONE NO.
						( )

INSURED'S EMPLOYER	WORK PHONE NO.
	( )

SECONDARY INSURANCE COMPANY	EFF. DATE	POLICY #	GROUP #	CERTIFICATE #

ADDRESS	CITY	ZIP CODE	STATE	ZIP CODE	PHONE NO.
					( )

NAME OF INSURED	PATIENT RELATIONSHIP TO INSURED	SOCIAL SECURITY #	DOB	SEX/Sexo (CIRCLE ONE) M F

INSURED'S ADDRESS	APT. #	CITY	STATE	ZIP CODE	COUNTRY	HOME PHONE NO.
						( )

INSURED'S EMPLOYER	WORK PHONE NO.
	( )

AUTHORIZATION INFORMATION

ASSIGNMENT OF BENEFITS:

I hereby assign to The Spine Institute any insurance or other third-party benefits available for health care services provided to me. I also understand that if benefits are assigned, or if by contractual arrangement, payment to the practice will be made by my insurance, that I am responsible for any co-payments and deductibles and that these amounts are due at the time services are rendered. I understand that the above practice has the right to refuse or accept assignment of such benefits (except when prohibited by contract). I also understand that in the event that services rendered are not covered under my "insurance", I will accept financial responsibility for all services provided to me. If benefits are not assigned to this practice, I agree to forward to the practice, all "insurance" payments that I receive for services rendered to me immediately upon receipt and/or to make payment, in full, for the services rendered to me (depending upon the agreement) at this time.

Signature of Patient/Legal Guardian: _____ Date: _____

FOR RELEASE OF INFORMATION:

I authorize the release of any medical or other information as is necessary to process this claim based upon the "HIPAA Notice of Privacy Practices" information provided to me under separate cover. This information is on file as a permanent record and may be amended as is necessary.

Signature of Patient/Legal Guardian: _____ Date: _____