NEW YORK MEDICAL COLLEGE

A MEMBER OF THE TOURO COLLEGE AND UNIVERSITY SYSTEM

Family Health Center

Patient Registration Form

Today's Date: _____ **NYMC Family Health Center**

Patient Information

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ City: _____

State: _____ Zip Code: _____

Home Number: _____ Cell Number: _____

E-mail: _____ Pharmacy: _____

DOB: _____ Age: _____ Sex: _____

Insurance Information

Please bill to: ○ Patient ○ Insurance Patient relationship to insured: ○ Self ○ Dependent

Primary Insurance Name: _____ Policy/ID #: _____

Insured's Name (if different from patient): _____

Insured's Social Security #: _____ Group Number: _____

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Emergency Contact

Last Name: _____ First Name: _____

Address: _____

Phone Number: _____ Relationship: _____

How did you hear about us? ○ Dental School ○ NYMC ○ Friend ○ Student Health ○ Other

Please read and sign next form