COLUMBIA UNIVERSITY MEDICAL CENTER

Discover. Educate. Care. Lead.

Registration Form

For office use only

MRN Number_____ Dx._____

Name_____

Street Address _____

City_____ State_____ Zip code_____

Home Phone Number_____ Daytime Number_____

Cell Phone_____Email Address_____

Date of Birth (mm/dd/yyyy)_____ S.S. # _____

Sex Male/ Female Marital Status: Single Married Separated Divorced Widowed

Father's First Name_____ Mother's First Name_____

Employer_____ Occupation_____

Employer's Address_____ City, State, Zip_____

Primary Care Physician_____

Office Phone Number_____ Fax Number_____

Address_____ City, State, Zip_____

Referring Physician_____

Office Phone Number_____ Fax Number_____

Address_____ City, State, Zip _____

Insurance Information

Primary Insurance

InsuranceCompany_____

Name of Policy Holder_____

Policy number_____Group Number_____

Address _____City, State, Zip _____

Secondary Insurance

Insurance Company_____

Name of Policy Holder_____

Policy number_____ Group Number_____

Address _____ City, State, Zip _____

Policy Holder name (If different than patient)_____

S.S# _____ Date of Birth (mm/dd/yyyy)_____

Employer_____

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr._____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment or benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____

Responsible Party Signature *Relationship* *Date*