Elena Sanders, MD, P.C.

400 Seaview Ave

Staten Island, NY 10305

Phone 718-980-0055 Fax 718-980-0058

PATIENT REGISTRATION FORM

PCP name and contact info:

PATIENT INFORMATION

Last Name:	First Name:	MI:	❑ Male ❑ Female	Date of Birth: / /	Marital status (circle): Single / Mar / Div / Sep / Wid

Street address:	Social Security #:	Home phone no.: ( )

City:	State:	Zip Code:	Cell phone no: ( )
Ethnicity: ❑ Hispanic ❑ Non-Hispanic	Race:	Language:	Email:

Occupation:	Employer name and address:	Employer phone no.: ( )

How did you hear about us? (please check one box):	❑ Dr. _______________	❑ Insurance Plan	❑ Hospital
❑ Family/friend	❑ Magazine ad (please specify)	❑ Other	

INSURANCE INFORMATION

Person responsible for bill:	Date of Birth: / /	Address (if different):	Home phone no.: ( )

Soc. Sec. #	Occupation:	Employer name and address:	Employer phone no.: ( )

Primary Insurance:	Subscriber's name:	Policy no.:	Group no.:
Secondary insurance (if applicable):	Subscriber's name:	Policy no.:	Group no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of a relative or friend to be notified:	Relationship to patient:	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 Elena Sanders, MD, P.C. or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*