New York Medical Associates, PC
635 Madison Avenue Third Floor New York, NY 10022
212-439-6690 Fax: 212-249-6856

Patient Registration

Name: (Last)_____ **(First)** _____ **(Middle)** _____

Address:_____

City: _____ **State:**_____ **Zip**: _____ **Country:** _____

Birth Date: _____ **Phone:** _____ **Work:**_____ **Fax:** _____

Contact By: *Phone* *Paper* *Fax* *Email* **Email:** _____ **Sex:** *M* *F*

Marital Status: *Single* *Married* *Divorced* *Widowed* *Separated* *Other* **SSN:** _____

Race: *Black* *Hispanic* *Native American* *Oriental/Asian* *White* *Other* **Language:** _____

Chinese *Filipino* *Native Hawaiian* *Multiracial* *Pacific Islander* *Japanese*

Employment Status: *Full-time* *Part-time* *Self-employed* *Retired* *Student* *Child* *Unemployed* *Other*

Responsible Party (Party responsible for payment) : *Self* *Spouse* *Parent* *Other*

Name: (Last)_____ **(First)** _____ **(Middle)** _____

Address:_____

City: _____ **State:**_____ **Zip**: _____ **Country:** _____

Phone: _____ **Work:** _____ **Fax:** _____ **Email:** _____

Primary Insurance:_____

Insured Party: *Self* *Spouse* *Parent* *Other* **Group #:** _____ **ID #:** _____ _____

Name: (Last)_____ **(First)** _____ **(Middle)** _____

Address:_____

City: _____ **State:**_____ **Zip**: _____ **Country:** _____

Phone: _____ **Work:** _____ **Fax:** _____

Secondary Insurance:_____

Insured Party: *Self* *Spouse* *Parent* *Other* **Group #:** _____ **ID #:** _____ _____

Name: (Last)_____ **(First)** _____ **(Middle)** _____

Address:_____

City: _____ **State:**_____ **Zip**: _____ **Country:** _____

Phone: _____ **Work:** _____ **Fax:** _____