North Shore LIJ

NORTH SHORE-LIJ Orthopaedic Institute

1000 Northern Blvd
Suite 110
Great Neck, NY 11021
516-325-7240

Physician for Today's Appt _____ Date: ___/___/_____

Patient Registration Form

*In order to serve you better, please **PRINT** and complete all information*

Last Name: _____ First Name: _____ MI: _____
Date of Birth: ___/___/_____ Age: ___ Sex: ☐M ☐F Marital Status: ☐Sing ☐Mar ☐Wid ☐Div
Street Address _____
City: _____ State: _____ Zip: _____ Email: _____
Phone: (Home) _____ (Cell) _____ (Work) _____
Employer: _____ Occupation: _____

Financially Responsible Party: ☐Same as above (if not, please fill in below)
Last Name: _____ First Name: _____ MI: _____
Date of Birth: ___/___/_____ Age: ___ Sex: ☐M ☐F Relationship: ☐Spouse ☐Parent
Address: _____
Phone: (Home) _____ (Cell) _____ (Work) _____

Emergency Contact
Name: _____ Phone #: _____ Relationship to patient: _____
Do you have a health care proxy? ☐Yes ☐No

Primary Care Physician:
Name: _____ Phone #: _____ Fax #: _____
Address: _____

Referring Physician:
Name: _____ Phone #: _____ Fax #: _____
Address: _____

Is this injury: Work related? ☐Yes ☐No **If yes, please fill out Worker's Comp questions attached**
Motor Vehicle Accident? ☐Yes ☐No **If yes, please fill out No Fault questions attached**

Insurance Information:
Primary Insurance: _____ Policy #: _____ Group #: _____
Subscriber's Name: _____ Date of Birth: ___/___/_____
Relationship to Patient: _____
Secondary Insurance: _____ Policy #: _____ Group #: _____
Subscriber's Name: _____ Date of Birth: ___/___/_____
Relationship to Patient: _____
Do you need a referral? ☐Yes ☐No Referral or tracking #: _____

Please be advised that if a referral is required, it must be obtained prior to seeing one of our providers.
If you fail to obtain the referral, you will be responsible for full payment for the services provided.

Pharmacy Information:
Name: _____ Phone #: _____ Fax #: _____
Address: _____

Signature of Patient: _____ **Date:** _____

Patient Representative Name **Signature** **Relationship** **Date**

Please provide the front desk with your insurance card and a photo ID.