North Shore LIJ
North Shore-Long Island Jewish Health System

# CHILDREN'S HEALTH NETWORK REGISTRATION FORM

**PATIENT NAME:** _____ Sex: _____ Date of Birth: ____/____/____
LAST FIRST M.I.

Patient's Social Security No.: _____ Marital Status: _____

Patient's Street Address: _____

Zip Code: _____ City, State: _____

Patient's Phone #: ( ) _____ Alternate Phone #: ( ) _____

**REFERRING PHYSICIAN NAME:** _____

**REFERRING PHYSICIAN ADDRESS:** _____

_____ ( ) _____
CITY STATE ZIP PHONE

Is the referring physician the patient's Primary Care Physician? _____ Reason for Visit: _____

## PATIENT/LEGAL GUARDIAN/GUARANTOR INFORMATION:

**GUARANTOR:** _____
LAST FIRST M.I.

| | |
|---|---|
| 1. Father's Name: _____ LAST FIRST M.I. | Mother's Name: _____ LAST FIRST M.I. |
| 2. Street Address: _____ | Street Address: _____ |
| 3. Zip Code: _____ | Zip Code: _____ |
| 4. City, State: _____ | City, State: _____ |
| 5. Social Security #: _____ | Social Security #: _____ |
| 6. Date of Birth: _____ | Date of Birth: _____ |
| 7. Employer Name: _____ | Employer Name: _____ |
| 8. Employer Address: _____ | Employer Address: _____ |
| 9. Employer Phone #: ( ) _____ | Employer Phone #: ( ) _____ |

**INSURANCE INFORMATION:** Please check the type(s) of insurance plans under which patient is covered:

☐ Commercial (Indemnity type) ☐ Managed Care ☐ Medicaid ☐ Medicaid Managed Care ☐ Medicare ☐ Other

**MEDICAID #** _____ **MEDICARE #** _____

**PRIMARY** Insurance Company Name: _____ Effective Date: _____

Primary Insurance Company Address: _____

Name of Policy Holder: _____ Certificate No.: _____

Group No.: _____ Plan No.: _____ Ins. Co. Phone No.: _____

Relationship of Patient to Policyholder: ____ Dependent Child ____ Other ____ Co-Pay $ _____ (Amt.) ____ No Co-Pay

**SECONDARY** Insurance Company Name: _____

Secondary Insurance Company Address: _____ Effective Date: _____

Name of Policy Holder: _____ Certificate No.: _____

Group No.: _____ Plan No.: _____ Ins. Co. Phone No.: _____

Relationship of Patient to Policyholder: ____ Dependent Child ____ Other ____ Co-Pay $ _____ (Amt.) ____ No Co-Pay

**PLEASE NOTE: MANAGED CARE INSURANCE REQUIRES REFERRAL TO A SPECIALIST BY THE PRIMARY CARE PHYSICIAN, EITHER IN WRITING OR BY AUTHORIZATION NUMBER, ACCORDING TO THE POLICY. IF SUCH REFERRAL IS NOT PROVIDED, PARENT, LEGAL GUARDIAN OR GUARANTOR MAY BE RESPONSIBLE FOR PAYMENT.**

**Authorization for release of information by Clinical Practice Plan and NSUH.**

I hereby authorize and direct the above named clinical practice, having treated my dependent, to release to governmental agencies, insurance carriers, or others who are financially liable for my medical care, all information needed to substantiate payment for such medical care and to permit representatives thereof to examine and make copies of all records relating to such care and treatment.

_____ _____
DATE SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE

Assignment to _____

I hereby assign, transfer, and set over to the above named clinical practice sufficient monies and/or benefits to which I may be entitled from governmental agencies insurance carriers, or others who are financially liable for my or my dependent's medical care to cover the costs of the care and treatment rendered to myself or my dependent in said practice.

_____ _____
DATE SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE



WHITE—CPP COPY CANARY—CHART COPY