AVENUE MEDICAL ASSOCIATES, P.C.

178 East 85th Street, NY, NY 10028 - TEL: (212)861-8976 - FAX: (212) 472-8396

❑ ROBERT ABRAMS, M.D. ❑ JULIAN KLAPOWITZ, M.D.

PATIENT REGISTRATION FORM

Name: _____
Last First Middle Initial

Street: _____ City: _____ State: _____ Zip: _____

Gender: ❑ Male ❑ Female Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed

Home Phone: _____ Cell Phone: _____

Birth Date: _____ Age: _____ Email: _____

Employer's Name: _____ Occupation: _____

Employer's Address: _____ Work Phone: _____

Name of Pharmacy: _____ Pharmacy Phone: _____

Name of Spouse: _____ Spouse Occupation: _____

Spouse's Cell Phone: _____ Spouse Work Phone: _____

Referred by: _____

In case of **EMERGENCY** please contact:

_____ _____
Name Phone#

****MEDICARE PATIENTS ONLY****

I request payment of authorized Medicare benefits be made either to me or on my behalf to Avenue Medical Associates, P.C. for services furnished to me by the provider. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits payable for related services.

_____ _____
Patient's Signature Date

I request that payment of authorized Medigap benefits be made either to me or on my behalf to the provider of service and (or) supplier for any services furnished to me by the provider of service and (or) supplier. I authorize any holder of Medicare information about me to release to my Medigap insurance: _____ any information needed to determine these benefits payable for related services.

HIC# _____

_____ _____
Patient's Signature Date

****NON-MEDICARE CARRIERS****

I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

_____ _____ _____ _____
Patient's Signature Date Provider's Signature Date

PRIMARY INSURANCE _____

Policy#: _____ Group#: _____

MEDICARE? ❑ Yes ❑ No Medicare#: _____

Insured's Name if not the Patient:

Name: _____

Street: _____ City: _____ State: _____ Zip: _____

Patient's relation to Insured: ❑ Self ❑ Spouse ❑ Child ❑ Other

DOB of Policy Holder (if different from patient): _____

Does your Health Insurance pay for a Well Visit? ❑Yes ❑No

SECONDARY INSURANCE: _____

Policy#: _____ Group#: _____

MEDICARE? ❑ Yes ❑ No Medicare#: _____

Insured's Name if not the Patient:

Name: _____

Street: _____ City: _____ State: _____ Zip: _____

Patient's relation to Insured: ❑ Self ❑ Spouse ❑ Child ❑ Other

DOB of Policy Holder (if different from patient): _____

Does your Health Insurance pay for a Well Visit? ❑Yes ❑No