FARMINGDALE PRIMARY CARE P.C.
Dr. Ronan Monsef

REGISTRATION FORM

(Please Print)

Today's date:

PATIENT INFORMATION

Patient's last name: First: Middle: Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Marital status (choose one) Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐

Is this your legal name? Yes ☐ No ☐ | If not, what is your legal name? | Smoking Status: Smoker ☐ Non Smoker ☐ Former Smoker ☐ | Birth date: | Age: | Sex: M ☐ F ☐

Street address / PO Box: | Social Security no: | Home phone no:

Mobile no: | City: | State: | ZIP Code:

Occupation: | Employer: | Email address:

Race:
White ☐ Black or African American ☐ Native American ☐ Asian ☐ Hispanic ☐ Other ☐ Decline to offer ☐

Ethnicity:
Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Decline to offer ☐

Language:
English ☐ Spanish ☐ Other ☐

Referred by:
Relative ☐ Physician ☐ Hospital ☐ Other ☐

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Is this patient covered by insurance? Yes ☐ No ☐

Please indicate primary insurance Aetna ☐ BCBS ☐ UHC/OX ☐ GHI ☐ Cigna ☐ Magnacare ☐ Other ☐

Subscriber's name: | Subscriber's S.S no.: | Birth date: | Group no: | Policy no / Member no / ID number:

Patient's relationship to subscriber: Self Spouse Child Other

Name of secondary insurance (if applicable) | Subscriber's name: | Group no.: | Policy no.:

Patient's relationship to subscriber:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address): | Relationship to patient: | Home 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 FARMINGDALE PRIMARY CARE or insurance company to release any information required to process My claims.

Patient/Guardian signature | Date