Internal Medicine & Geriatrics, PLLC
Stella Pinhas, MD

94-12 59th Ave, Unit E5
Elmhurst, NY 11373
(718) 997-7117

PATIENT REGISTRATION

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

Birthdate: _____ (mm/dd/yyyy) Social Security #: _____ Gender: **Male / Female**

Address: _____ (Street) _____ (City) _____ (State) _____ (Zip)

Home Tel: _____ Cell Tel: _____ Work Tel: _____

Marital Status: ☐ Married ☐ Widowed ☐ Single ☐ Separated ☐ Divorced ☐ Partners for _____ years

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Employer: _____ Job Title: _____

Emergency Contact Info:

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

Home Tel: _____ Cell Tel: _____ Work Tel: _____

Relationship to patient: _____

Primary Insurance:

Name of Insurance Company: _____ Telephone: _____

Address: _____ (Street) _____ (City) _____ (State) _____ (Zip)

Policy #: _____ Group: _____

Secondary Insurance / Co-Insurance:

Name of Insurance Company: _____ Telephone: _____

Address: _____ (Street) _____ (City) _____ (State) _____ (Zip)

Policy #: _____ Group: _____

If primary policy coverage is under someone other than patient, fill in below:

Policy Holder Name: _____ (Last Name) _____ (First Name) _____ (Middle Name)

Birthdate: _____ (mm/dd/yyyy) Social Security #: _____ Gender: **Male / Female**

Address (if different): _____ (Street) _____ (City) _____ (State) _____ (Zip)

Home Tel (if different): _____ Cell Tel: _____ Work Tel: _____

Relationship to patient: _____

* If secondary / co-insurance coverage is also under someone other than patient, complete same information as above on the back of form.

Assigment And Release:

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ (Name of Insurance Company(ies))

and assigned directly to Dr. Stella Pinhas, MD all insurance benefits, if any, otherwise payable to me for services rendered.
I understand that I am financially responsible for all charges whether or not paid by insurance and am also responsible for all referrals needed for reimbursement. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____ Relationship: _____ Date: _____

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PATIENT REGISTRATION

(Additional Patient Info)

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

E-mail: _____

Best time and place to reach you: _____

Race: ☐ Asian ☐ Black ☐ Caucasian ☐ American Indian or Alaska Native ☐ Pacific Islander ☐ Other Race

Ethnic Group: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Religion: _____

Pharmacy Name: _____

Pharmacy Phone: _____

Referring Physician: _____

Who referred you to our office: _____

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