

BETH ISRAEL MEDICAL CENTER

FIRST AVENUE AT 16TH STREET, NEW YORK, NY 10003



258

PLEASE PRINT ALL INFORMATION

NEW PATIENT REGISTRATION FORM

DATE	APPOINTMENT WITH	MR #
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PATIENT INFORMATION

PATIENT'S LAST NAME/Apellido Del Paciente	FIRST NAME/Primer Nombre	ALLERGIES	DATE OF BIRTH/Fecha de Nacimiento	AGE/Edad
STREET ADDRESS/Dirección	APT.#	SOCIAL SECURITY#/Seguro Social#	SEX/Sexo (CIRCLE ONE) M F	
CITY/Ciudad	STATE/Estado	ZIP CODE/Zona Postal	HOME PHONE NO./Telefono De Casa ()	MARITAL STATUS/Estado Matrimonial S M W D SP
SPOUSE'S NAME	SPOUSE'S WORK NO. ()	EXT.	MOTHER'S MAIDEN NAME	
PATIENT'S EMPLOYER/Patron Del Paciente	PATIENT'S WORK NO. ()	EXT.	F/T STUDENT Y N	
EMPLOYERS ADDRESS/Dirección Del Patron	CITY/Ciudad	STATE/Estado	ZIP CODE/Zona Postal	
EMERGENCY CONTACT PERSON/Contacto De Emergencia	RELATIONSHIP TO PATIENT	CONTACT'S HOME PHONE NO. ()	CONTACT'S WORK PHONE ()	EXT.
REFERRING MD NAME	ADDRESS	CITY	STATE	ZIP CODE
PHONE NO. ()				
PRIMARY DOCTOR NAME/Nombre Del Medico de Cabezera	ADDRESS/Dirección	CITY/Ciudad	STATE/Estado	ZIP CODE/Zona Postal
PHONE NO. ()				

GUARANTOR INFORMATION - Person responsible for payment, if other than self

GUARANTOR'S LAST NAME/Apellido Del Fiador	FIRST NAME/Primer Nombre	RELATIONSHIP TO PATIENT/Relación al Paciente
GUARANTOR'S ADDRESS/Dirección Del Fiador	APT.#	SOCIAL SECURITY#/Seguro Social#
DATE OF BIRTH/Fecha de Nacimiento	CITY	STATE
ZIP CODE	HOME PHONE NO. ()	SEX (CIRCLE ONE) M F
GUARANTOR'S EMPLOYER	WORK PHONE NO. ()	EXT.
EMPLOYERS ADDRESS	CITY	STATE
ZIP CODE		

MEDICARE #	EFF. DATE	MEDICAID #	EFF. DATE
PRIMARY INSURANCE COMPANY NAME	EFF. DATE	POLICY #	
ADDRESS	GROUP # ()	CERTIFICATE #	
CITY	STATE	ZIP CODE	PHONE NO. ()
EXT.	RELATIONSHIP TO PATIENT		
SECONDARY INSURANCE COMPANY NAME	EFF. DATE	POLICY #	
ADDRESS	GROUP # ()	CERTIFICATE #	
CITY	STATE	ZIP CODE	PHONE NO. ()
EXT.	RELATIONSHIP TO PATIENT		

AUTHORIZATION INFORMATION

Signature:	Date:	Signature:	Date:
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BIMC 32-185 (7/95)