DR. DARLENE POWELL GARLINGTON
2280 Grand Avenue, Suite 304 • Baldwin, NY 11510

PATIENT REGISTRATION FORM

PATIENT INFORMATION:

Patient's Name (Last)_____ (First) _____ (MI)_____

Date of Birth: _____/_____/_____ ☐ Female ☐ Male Social Security No.: _____-_____-_____

Phone Numbers: Home: _____ Cell: _____ Work:_____

Mailing Address: _____

City, State, Zip: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Other

Employment Status: ☐ Employed ☐ Full-Time Student ☐ P/T Student ☐ Retired ☐ Self-Employed ☐ Unemployed

Employer:_____ Occupation:_____

E-Mail Address: _____

Emergency Contact Name:_____ Phone Number:_____

Emergency Contact Relationship to Patient:_____

RESPONSIBLE PARTY INFORMATION:

Responsible Party Name (Last)_____ (First)_____ (MI)_____

Date of Birth: _____/_____/_____ ☐ Female ☐ Male Social Security No.: _____-_____-_____

Phone Numbers: Home: _____ Cell: _____ Work:_____

Mailing Address: _____

City, State, Zip: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Other

Employment Status: ☐ Employed ☐ Full-Time Student ☐ P/T Student ☐ Retired ☐ Self-Employed ☐ Unemployed

Employer:_____ Employer Phone No.::_____

Patient Relationship to Responsible Party:_____

PRIMARY INSURANCE INFORMATION:

Name of Subscriber:_____ Patient Relationship to Subscriber:_____

Patient Date of Birth: _____/_____/_____ **Subscriber** Date of Birth: _____/_____/_____

Social Security #.: _____-_____-_____ Ins. ID No.:_____

Provider Phone Number *(from back of card)* _____

Mailing Address: _____

Insurance Plan Name: _____

SECONDARY INSURANCE INFORMATION:

Name of Subscriber:_____ Patient Relationship to Subscriber:_____

Patient Date of Birth: _____/_____/_____ **Subscriber** Date of Birth: _____/_____/_____

Social Security #.: _____-_____-_____ Ins. ID No.:_____

Provider Phone Number *(from back of card)* _____

Mailing Address: _____

Insurance Plan Name: _____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature: _____ ***Date:***_____