Sheikh Medical Care PLLC

103-02 93RD ST, OZONE PARK,
New York 11417
Tel: 718-487-3944
Fax: 718-487-3929
E-mail: sheikhmedicalcarepllc@gmail.com

PATIENT REGISTRATION FORM

Patient Information (please clearly print with details)			Today's Date
Patient's First Name:		Patients Last Name:	Middle Initial:
City and State:		Street Address & Unit #:	Zip Code:
Patient Cell Phone:		Patient Home Phone:	Patient Work Phone:
◉ Male ○ Female	Date of Birth: Age:	Patient's Social Security #:	CO Drivers License #
Patient's Occupation:		Spouse Name, Address and Phone:	
Marital Status: ◉ Single ○ Married ○ Divorced		Patient's Employer and Address:	
Name of the Parent if Patient is a minor:			
Physician you 're here to visit today:		State the main reason for visit briefly:	
Who referred you to us?		Emergency contact information of a person who is not living with you: Name: Phone #: Relationship	
Primary Insurance:			
Primary Insured's Employer Name and Address:			Primary Insured's Name:
ID # or Member (Social Security # of person Insured):			
Primary Insured's Actual Relation to Patient:		Primary Insured's Social Security #:	Primary Insured's DOB:
Primary Ins. Co Mail Claims to Address:		Primary Ins. Co Phone # (benefits or claims):	Primary Ins. Co Group #:
Secondary Insurance:			
Secondary Insured's Employer Name and Address:			Secondary Insured's Name:
Member or ID # (Social Security Number of person insured):			
Secondary Insured's Relation to Patient:		Secondary Insured's Social Security #:	Secondary Insured's DOB:
Secondary Ins. Co Mail Claims to Address:		Primary Ins Co Phone # (benefits or claims):	Primary Ins Co Group #:

RELEASE AND ASSIGNMENT OF BENEFITS: I guarantee the accuracy of the patient's information mentioned above and understand that I'm responsible for the number of basic charges regardless of their insurance coverage. Plus, I authorize the release of necessary medical data and information to my notable insurance career(s) or their/it's representative for major purposes essential in the processing or adjudication of any insurance claims filed on my behalf & for which I'm financially responsible as well. Further, I authorize all insurance perks and benefits to be paid to the different rendering services provider on behalf of South Denver International Medicine & Pediatrics, PC. (I herby consent to treatment by my own physician.)

Patient's Signature: _____ **Date:** _____