University Hospital of
Columbia University College
Of Physicians & Surgeons.

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NEW PATIENT REGISTRATION

PATIENT LAST NAME	**FIRST**	**MIDDLE**	
DATE OF BIRTH	**AGE**	**GENDER (CIRCLE ONE)** **MALE FEMALE**	
SOCIAL SECURITY NUMBER	**HOME NUMBER**	**CELL NUMBER**	
STREET ADDRESS	**CITY**	**STATE**	**ZIPCODE**
MARITAL STATUS (CIRCLE ONE) **SINGLE MARRIED DIVORCED WIDOWED**		**EMAIL ADDRESS**	
PLACE OF EMPLOYMENT	**WORK NUMBER**		

EMERGENCY CONTACT

CONTACT NAME	**CONTACT ADDRESS**	**CONTACT PHONE NUMBER**
EMERGENCY CONTACT RELATIONSHIP TO PATIENT		

REFERRING DOCTOR & PRIMARY CARE INFORMATION

REFERRED TO DR. WHELAN'S OFFICE BY (CIRCLE ONE)

DOCTOR FAMILY FRIEND INTERNET INSURANCE HOSPITAL OTHER

NAME OF PRIMARY CARE DOCTOR	**OFFICE ADDRESS**	**TELE PHONE**

PHARMACY INFORMATION

NAME OF PHARMACY	PHARMACY TELEPHONE #	PHARMACY FAX #	PHARMACY EMAIL

PHARMACY ADDRESS

AUTHORIZATION INFORMATION

I HEREBY ASSIGN DR. RICHARD WHELAN ANY INSURANCE OR OTHER THIRD-PARTY BENEFITS AVAILABLE FOR HEALTH CARE SERVICES PROVIDED TO ME. I ALSO UNDERSTAND THAT IF BENEFITS ARE ASSIGNED, OR IF BY CONTRACTUAL ARRANGEMENT, PAYMENT TO THE PRACTICE WILL BE MADE BY MY INSURANCE, THAT I AM RESPONSIBLE FOR ANY CO-PAYMENTS AND DEDUCTIBLES AND THAT THESE AMOUNTS ARE DUE AT THE TIME SERVICES ARE RENDERED. I UNDERSTAND THAT DR. WHELAN'S PRACTICE HAS THE RIGHT TO REFUSE OR ACCEPT ASSIGNMENT OF SUCH BENEFITS (EXCEPT WHEN PROHIBITED BY CONTRACT.) I ALSO UNDERSTAND THAT IN THE EVENT THAT SERVICES RENDERED ARE NOT COVERED UNDER MY "INSURANCE", I WILL ACCEPT FINANCIAL RESPONSIBILITY FOR ALL SERVICES PROVIDED TO ME. IF BENEFITS ARE NOT ASSIGNED TO THIS PRACTICE, I AGREE TO FORWARD TO THE PRACTICE ALL "INSURANCE" PAYMENTS THAT I RECEIVE FOR SERVICES RENDERED TO ME IMMEDIATELY UPON RECEIPT AND/OR TO MAKE PAYMENT, IN FULL, FOR THE SERVICES RENDERED TO ME (DEPENDING UPON THE AGREEMENT AT THIS TIME.)

SIGNATURE OF PATIENT/ LEGAL GUARDIAN **DATE**

X_____ _____

DOCTOR / PATIENT CONFIDENTIALITY AGREEMENT

IF YOU WANT TO GIVE AUTHORIZATION TO DR. WHELAN AND/OR HIS STAFF TO DISCUSS YOUR MEDICAL INFORMATION WITH ANOTHER INDIVIDUAL OF YOUR CHOOSING, PLEASE WRITE INDIVIDUAL'S NAME AND SIGN THE FOLLOWING.

I, _____ **AUTHORIZE DR. WHELAN AND HIS STAFF TO DISCUSS MY**
(PRINT NAME)

MEDICAL HEALTHCARE INFORMATION WITH _____**.**
(PRINT NAME)

SIGNATURE OF PATIENT/ LEGAL GUARDIAN **DATE**

X_____ _____