North Shore LIJ Lenox Hill Hospital

FORM A - REGISTRATION

DATE OF SURGERY:	OB DUE DATE:	PHYSICIAN'S NAME:

100 East 77th Street, NY, NY 10075-1850 - Surgical Cases Fax to: **866-219-5545** / 210 East 64th Street, NY, NY 10065-7471 - Surgical Cases Fax to: **866-231-1027**

PATIENT INFORMATION

NAME - Last: First:

ADDRESS - Street: City: Apt #: State: Zip:

COUNTY OF RESIDENCE: PHONE: ( ) Email

RACE:
☐ Asian ☐ American Indian
☐ Black ☐ Native Hawaiian
☐ White ☐ Other _____

ETHNICITY:
☐ Hispanic / Latino ☐ Not-Hispanic Latino

Preferred Language: _____

GENDER: _____

MARITAL STATUS:
☐ Married ☐ Widowed
☐ Single ☐ Divorced
☐ Separated

DATE OF BIRTH:
_____ MONTH _____ DAY _____ YEAR

MOTHER'S MAIDEN NAME:

PATIENT'S MAIDEN NAME:

PLACE OF BIRTH:

Are you an Employee of LHH / MEETH? ☐ Yes ☐ No

RELIGION:

ADVANCE DIRECTIVES:
☐ Yes *(Provide Copy)* ☐ No
Type: ☐ Healthcare Proxy
☐ Living Will
☐ Do Not Resuscitate
☐ Other: _____ SPECIFY

Do You Carry an Organ Donor's Card?
☐ Yes ☐ No

OCCUPATION:

EMPLOYER:

EMPLOYER ADDRESS- Street:

City: State: Zip:

Length of Service With Current Employer: Years Months

EMPLOYER'S PHONE: ( )

EMPLOYMENT STATUS: ☐ Employed ☐ Disabled ☐ Unemployed ☐ Retired

ACCIDENT INFORMATION - *IF THIS ADMISSION IS THE RESULT OF AN ACCIDENT, PLEASE COMPLETE THIS SECTION IN FULL*

TYPE OF ACCIDENT:
☐ Work Related ☐ Auto ☐ Home ☐ School ☐ Other

DATE OF ACCIDENT: Month Day Year

TIME OF ACCIDENT: ☐ AM ☐ PM

LOCATION OF ACCIDENT: Street City State Zip

PERSON RESPONSIBLE FOR FINANCIAL ARRANGEMENTS

NAME OF PERSON ON INSURANCE CARD: Last First

RELATIONSHIP TO PATIENT:

NAME: Last First

ADDRESS: Street Apt # City Zip

COUNTY OF RESIDENCE:

PHONE #: ( )

Email

EMPLOYMENT STATUS:
☐ Employed ☐ Unemployed ☐ Disabled ☐ Retired

GENDER:

BIRTH DATE:

OCCUPATION:

EMPLOYER:

EMPLOYER ADDRESS: Street City State Zip

PHONE: ( ) Ext:

PERSON TO CONTACT IN AN EMERGENCY

NAME: Last First

ADDRESS: Street City Apt # State Zip

RELATIONSHIP TO PATIENT:

HOME PHONE: ( )

WORK PHONE: ( ) Ext:

IF PATIENT IS 18 OR UNDER (25 IF STUDENT) ENTER OTHER PARENT INFORMATION BELOW.
IF PATIENT IS MARRIED ENTER SPOUSE INFORMATION. OTHERWISE ENTER CLOSEST RELATIVE.

LEGAL NEXT OF KIN

NAME: Last First

ADDRESS: Street City Apt # State Zip

RELATIONSHIP TO PATIENT: **DATE OF BIRTH:**

HOME PHONE: ( )

WORK PHONE: ( ) Ext:

MISCELLANEOUS

Have you ever been an inpatient at Lenox Hill Hospital / MEETH? ☐ Yes ☐ No

If Yes, under what name? _____ **DATES: From** Mo Day Yr **To** Mo Day Yr

Have you ever been an inpatient in another Hospital or Skilled Nursing Facility within the last 60 days? ☐ Yes ☐ No

If Yes, under what name? _____ **DATES: From** Mo Day Yr **To** Mo Day Yr

Name of Institution: _____

North Shore LIJ Lenox Hill Hospital

FORM B - REGISTRATION

DATE OF SURGERY:	PHYSICIAN'S NAME:

100 East 77th Street, NY, NY 10075-1850 - Surgical Cases Fax to: **866-219-5545** / 210 East 64th Street, NY, NY 10065-7471 - Surgical Cases Fax to: **866-231-1027**

INSURANCE INFORMATION

PLEASE COMPLETE THE APPROPRIATE SECTIONS BELOW FOR BOTH PATIENT AND SPOUSE, OR BOTH PARENTS IF PATIENT IS 21 OR UNDER . . . **AND ATTACH A COPY OF BOTH SIDES OF THE INSURANCE CARDS.**

MEDICARE

MEDICARE **HEALTH INSURANCE**

SOCIAL SECURITY ACT

Name of Beneficiary

Claim Number Sex

Is Entitles To Effective Date

Hospital (Part A)

Hospital (Part B)

OTHER BLUE CROSS

BLUE CROSS / BLUE SHIELD OF (State):

SUBSCRIBER'S NAME:

IDENTIFICATION:

MEDICARE PATIENTS OR SPOUSE:

ARE YOU RETIRED? ☐ YES ☐ NO

IS YOUR SPOUSE RETIRED? ☐ YES ☐ NO

DO YOU HAVE OTHER INSURANCE? ☐ YES ☐ NO

IF SPOUSE IS EMPLOYED, PLEASE PROVIDE HIS/HER INSURANCE INFORMAITON ON THIS FORM.

DATE OF RETIREMENT: Patient _____ Spouse _____

OTHER INSURANCE (HMO, UNION, TRAVELERS, METROPOLITAN, ETC.)

NAME ON CARD: Last	First	EMPLOYER NAME: *(As it appears on card)*
		Address:
POLICY NUMBER: ID #	Group #	Phone:
PAYOR ID NUMBER:		INSURANCE COMPANY NAME:
		Address:
GROUP NAME:		Phone:

WORKERS COMP (ATTACH AUTHORIZATION FORM)

INSURANCE COMPANY: NAME	ADDRESS	PHONE: ( )
EMPLOYER: NAME	ADDRESS	PHONE: ( )

WCB #:	ACCIDENT DATE	ACCIDENT TIME: ☐ AM ☐ PM	CLAIM FILED: ☐ YES ☐ NO

NO-FAULT (ATTACH FORM FROM INSURANCE COMPANY)

INSURANCE COMPANY: NAME	ADDRESS	PHONE: ( )
CAR OWNER: NAME	ADDRESS	PHONE: ( )
INSURANCE AGENT OR ATTORNEY: NAME		PHONE: ( )

ACCIDENT DATE:	ACCIDENT TIME: ☐ AM ☐ PM	POLICY NUMBER:	FILE NO.:

MEDICAID

NAME ON CARD: LAST FIRST

ID NUMBER:

ISO #:	ACCESS NUMBER:	SEQ. #:

☐ **SELF PAY / UNINSURED**