NEW PATIENT REGISTRATION FORM

AAA VASCULAR CARE – DR. TOUFIC SAFA
900 NORTHERN BLVD, STE 140
GREAT NECK, NY 11201

PATIENT INFORMATION

Patient's last name: First: Middle:			Date of Birth:	Marital status (circle one) Single / Mar / Div / Sep / Wid
Email Address:	Is your visit work related? ❑ Yes ❑ No	Is your visit related to a Motor Vehicle Accident? ❑ Yes ❑ No		Sex: ❑ M ❑ F
Street address:		Social Security no.:		Home phone no.: ( )
City:	State:	Zip Code:		Cell Phone no: ( )
Name of Employer:	Address of Employer:			Employer phone no.: ( )
Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. _____ Phone #: _____ ❑ Family/Friend ❑ Hospital ❑ Close to home/work ❑ Internet ❑ Other _____				
Primary Care Physician Name & Address:			Primary Care Physician Phone # :	

INSURANCE INFORMATION

Primary Insurance:		**Secondary Insurance**:	
Member ID#:		Member ID#:	
Group #:		Group #:	
Subscriber's name:	Relationship:	Subscriber's name:	Relationship:
Subscriber's SS #:	Birth date:	Subscriber's SS #:	Birth date:

IN CASE OF EMERGENCY

Name of Emergency Contact:	Relationship to patient:	Home phone #: ( )	Work phone #: ( )

AUTHORIZATION FOR RELEASE OF INFORMATION BY AAA VASCULAR CARE

I hereby authorize and AAA Vascular Care, having treated me, to release to government agencies, insurance carriers, or others who are financially liable for my medical care, all information needed to substantiate payment for such medical care and to permit representatives therefore to examine and make copies of all records relating to such care and treatment.

Patient/Guardian signature _____ Date _____

I hereby assign, transfer, and set over to the above named faculty practice sufficient moneis and/or benefits to which I may be entitled from governmental agencies, insurance carries, or others who are financially liable for my medical care to cover the costs of the care and treatment rendered to myself or my dependent in said practice.

Patient/Guardian signature _____ Date _____