



Neighborhood Doctors Who Care

Patient Registration Form

Thank you for selecting Manhattan's Physician Group for your medical treatment. We will strive to provide you with the best care possible. To help us meet all of your healthcare needs, please fill out this form completely. If you have any questions or need assistance, do not hesitate to let us know and we will be happy to help.

Patient Demographic Information					
First Name:		Middle Initial:	Last Name:		
Sex:	Marital Status:	Birth Date:	/	/	SS #:
Address:	Apt #:	City:	State:	Zip:	
Home Phone #:	Work Phone #:		Cell Phone #:		
E-Mail Address:	May We Contact your E-Mail:		Y / N	Primary Language:	
Race:		Ethnicity:			
Primary Care Physician:		PCP Phone Number:			
Emergency Contact Person:			Relationship:		
Home Phone #:	Work Phone #:		Cell Phone #:		
Preferred Pharmacy Name:		Phone Number:	Address:		
Employer Name:		City:	State:	Zip:	

Insurance Information					
Primary Insurance Name:		Policy #:	Group #:		
Address:	City:	State:	Zip:		
Insured's Name:	Relation to Insured:		Insured's DOB: / /		
Effective Date: / /	Expiration Date: / /				
Secondary Insurance Name:		Policy #:	Group #:		
Address:	City:	State:	Zip:		
Insured's Name:	Relation to Insured:		Insured's DOB: / /		
Effective Date: / /	Expiration Date: / /				

Responsible Party Information (if different from above)					
First Name:		Middle Initial:	Last Name:		
Sex: M / F	Marital Status:	Birth Date:	/	/	SS #:
Address:	Apt #:	City:	State:	Zip:	
Home Phone #:	Work Phone #:		Cell Phone #:		

Informational
How did you hear about Manhattan's Physician Group? _____
Do you have an Advanced Directive(s): Y / N; If yes, what do you have? _____
<i>Please provide a copy of any Advanced Directives upon your next visit</i>
Please visit http://www.health.state.ny.us/forms/doh-1430.pdf for information on NYS Health Care Proxy

Patient Signature

Date

Witness Signature

Date