Michael J. Maynard, MD
520 East 72nd Street
New York, NY 10021
New# (212) 259-0436
Old# (212) 606-1587

HSS# _____

PATIENT REGISTRATION FORM

PLEASE PRINT CLEARLY. PLEASE PRINT BOTH YOUR LEGAL FIRST AND LAST NAME

Last Name_____ First Name _____M.I._____ Age_____

Address_____

City_____ State_____ Zip Code_____

Home Phone: (_____)_____ Work Phone: (_____)_____

Cell Phone: (_____)_____ Email:_____

Date of Birth (will be taken at your first visit) Social Security Number (will be taken at your first visit)

Marital Status_____ Sex_____ Ethnicity_____ Religion_____

Race_____ Preferred Language _____

Employer_____Occupation_____

Employer Address_____

City_____ State_____ Zip Code_____

Guarantor (person responsible for bill if other than patient)

Last Name_____First Name_____Middle Initial_____

Address_____

City_____ State _____ Zip Code_____

Home Phone: (_____)_____ Work: (_____)_____ Cell Phone:(_____)_____

Age_____ Date of Birth (will be taken at your first visit) Social Security Number (will be taken at your first visit)

Relationship to Patient_____

**********************SEE REVERSE SIDE*******************

Primary Insurance (Circle One) Medicare OR Private Insurance

Insurance Company Name_____

Insurance Company Address_____

City_____State_____Zip Code_____

Insurance Telephone Number(s)_____

Policy//ID#_____Group#_____Claim#_____

WCB# (If Workmen's Compensation)_____Date of Accident_____

Insured's Name_____Relationship to Patient_____

Secondary Insurance (Circle One) Medicare OR Private Insurance

Insurance Company Name_____

Insurance Company Address_____

City_____State_____Zip Code_____

Insurance Telephone Number(s)_____

Policy//ID#_____Group#_____Claim#_____

WCB# (if Workmen's Compensation)_____Date of Accident_____

Insured's Name_____Relationship to Patient_____

Person to be Notified in Case of Emergency – *Please provide a telephone number other than your own*

Name_____Sex_____Relationship to Patient_____

Address_____

City_____State_____Zip Code_____

Home Phone: (_____)_____Work Phone:(_____)_____Cell Phone (_____)_____

I certify that the information given above is correct
Patient or Guardian's Signature_____Date_____