

# Spring Ob/Gyn

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DATE: \_\_\_\_\_

## Patient Registration Form

Do you have an answering machine? **YES** or **NO**      If Yes, may we leave a message? Home: **YES** or **NO**  
Work: **YES** or **NO**  
Cell: **YES** or **NO**

### Patient Information

Name: \_\_\_\_\_ Soc Sec. # \_\_\_\_\_  
Last name First name Middle initial

Address: \_\_\_\_\_ Home tel: ( ) \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

S M D W Age: \_\_\_\_\_ Birthday: \_\_\_\_\_ Referred by: \_\_\_\_\_  
(marital status)

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Business Address: \_\_\_\_\_ Business tel: ( ) \_\_\_\_\_

Cell # ( ) \_\_\_\_\_ e-mail address: \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Emergency tel: ( ) \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

### Primary Insurance

Policy Holder: \_\_\_\_\_  
Last name First name Middle initial

Relationship to Patient: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Address (if different from patient): \_\_\_\_\_ Home tel: ( ) \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer: \_\_\_\_\_ Insurance Co: \_\_\_\_\_

Ins. ID # \_\_\_\_\_ Group # \_\_\_\_\_

**PLEASE SIGN ON THE BACK OF THIS FORM.**

**Assignment and Release**

I, the undersigned certify that I (or my dependent) have insurance coverage with \_\_\_\_\_ and assign directly to *Spring Ob/Gyn, PC* all insurance benefits, if any, otherwise payable to me for service rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment benefits. I authorize the use of the signature on all insurance submissions.

By signing this page I am also acknowledging receipt of the Privacy Notice provided by *Spring Ob/Gyn, PC*. I have read and understand my rights as a patient, as provided in this letter.

\_\_\_\_\_  
Responsible Party Signature

\_\_\_\_\_  
Date

I make the following special request for confidential communications:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_