

Spring Ob/Gyn, PC

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Patient Registration Form

Date: _____

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: _____

Marital status: S M D W

DOB: _____ Age: _____ Referred by: _____

Employer: _____ Occupation: _____

Work no: () Email address: _____

Cell no: () _____

Emergency contact: _____ Emergency tel: () _____

Relationship to patient: _____

Primary Insurance

Policy Holder: _____
Last name First name Middle initial

Relationship to patient: _____

Soc Sec. # _____ DOB: _____

Address: _____ Home tel: () _____
(if different from patient)

City: _____ State: _____ Zip: _____

Employer: _____ Insurance Co: _____

Insurance 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:
