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PATIENT REGISTRATION FORM

PLEASE PRINT CLEARLY BOTH YOUR LEGAL FIRST AND LAST NAME

Last Name _____ First Name _____ M.I. _____

Address _____

City _____ State _____ Zip Code _____

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

Cell Phone: (_____) _____ Email: _____

Date of Birth _____ Age _____ Social Security Number _____ - _____ - _____

Marital Status _____ Sex _____ Ethnicity _____ Religion _____

Employer _____ Occupation _____

Employer Address _____

City _____ State _____ Zip Code _____

Guarantor/Subscriber (person responsible for bill if other than patient/Insurance policy holder)

Last Name _____ First Name _____ Middle Initial _____

Address _____

City _____ State _____ Zip Code _____

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

Date of Birth _____ Age _____ Social Security Number _____ - _____ - _____

Relationship to Patient _____

*****PLEASE SEE PAGE 2*****

Primary Insurance (Circle One) Medicare Private Insurance Workmen's Compensation No Fault

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 Private Insurance Workmen's Compensation No Fault

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_____

Primary Care Physician

Name_____

Address_____

City_____State_____Zip Code_____

Office Phone: (_____)_____Fax Number:(_____)_____

I herby confirm that all of the above information is accurate. I understand that if my insurance carrier is inactive or not participating, I may be sent a bill for the remaining balance or co-payment.

Patient or Guardian's Signature_____ **Date**_____