NewLife
Obstetrics & Gynecology

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Brooklyn NY 11220
**T:** (718) 567-0730

**Bay Ridge**
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**T:** (929) 888-6996

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# Patient Registration

Reset Print

| | | | |
|---|---|---|---|
| First Name: | | Last Name: | |
| Social Security Number: | | Email: | |
| Address: | | City: | State: |
| Zip Code: | Home phone: | Work Phone: | Mobile Phone: |
| Date of Birth: | Ethnicity: | ◯ Male ◯ Female | ◯ Single ◯ Married ◯ Other |
| Occupation: | | Company Name: | |
| Emergency Contact: | | Phone: | Relationship: |

| | | | |
|---|---|---|---|
| Pharmacy Name: | | Address: | |
| City: | State: | Phone: | |

| | | | |
|---|---|---|---|
| Physician Name: | | Address: | |
| City: | State: | Zip Code: | Phone: |

Do you have insurance? ◯ Yes ◯ No

| | | | |
|---|---|---|---|
| Insurance Company Name: | | Insured's Name: | |
| Insurance ID# | | Insured's SSN: | |
| Insured's DOB: | ◯ Male ◯ Female | Relationship to patient | ◯ Self ◯ Spouse ◯ Child ◯ Other |

**Assignment of Insurance Benefits**

**I hereby authorize** direct payment of surgical/medical benefits to New Life OBGYN, for services rendered. I am financially responsible for any balance not covered by my insurance. I authorize any holder information about me to release to my health insurance carrier and its agents any information needed to determine these benefits or the benefits payable for related services.

**I hereby authorize** New Life OBGYN to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefits

| | |
|---|---|
| Parent/Guardian (Please Print): | Relationship: |
| Signature: | Date: |

REVISED 05/03/2016