NEW YORK–PRESBYTERIAN HOSPITAL REGISTRATION FORM

Referring Facility:

Phone:
Fax:
Contact Person:

Please print information

Date of request: _____ Patient CPMC Medical Record Number: _____

Patient Name: _____ Date of Birth: _____

Male ___ Female ___ Social Security # _____ Married ___ Single ___ Widowed ___ Divorced ___

Address: _____

Home/Cell Number: _____ Other contact Number: _____

Mother's First Name: _____ Father's First Name: _____

Insurance Plan: _____ Plan ID/Group Number: _____

Medicaid CIN Number: _____ Medicare Number: _____

Is the patient on an HMO plan? No ____ Yes (Plan name): _____
(Please remind patients to bring their referrals on date of appointment.)

Referring Physician Name: _____ UPIN #: (for diagnostic services) _____

Clinic Referred: _____ Diagnosis: _____ICD 9 Code: _____

Request to rule out/evaluate patient for: _____

Time frame physician is seeking for appointment: _____

Additional Information: (attach reports/lab results, medications taken/exams done/history etc. pertinent to patient care):

_____

_____

_____

_____

Patient appointment day/time preference: (we will try to schedule if clinic is available) _____

Please fax completed forms back to 212-342-6049. Any incomplete forms will be returned.