HIMANSHU PANDYA,MD
257-20 HILLSIDE AVENUE, FLORAL PARK, NY 11004
TEL: (718) 831-6600

REGISTRATION RECORD

Personal Information:

Last Name: _____ First Name: _____

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Home Phone: ( ) _____ Work Phone: _____

Cell Phone: _____

Date of Birth: _____/_____/_____ Male: _____ Female: _____

Social Security Number: _____

Marriage Status: Single _____ Married _____ Divorced _____ Separated _____ Widowed _____

Father: _____ Mother: _____

PRIMARY INSURANCE INFORMATION:

Insurance Co.: _____ Card Holder: _____

I.D. #: _____ Group #: _____

SECONDARY INSURANCE INFORMATION:

Insurance Co.: _____ Card Holder: _____

I.D. #: _____ Group #: _____

EMERGENCY INFORMATION:

Emergency Contact: _____ Relationship: _____

Day Phone: ( ) _____ Evening Phone: ( ) _____

I request that payment of authorized Medical Benefits be made on my behalf directly to the medical provider(s). I authorize any holder of medical information about me to be released to my insurance company and its agents to determine these benefits. I will be responsible for any deductibles, co-payments, or balances not paid for by my insurance company(s).

Signature _____