ANDREW G. WOOLRICH, M.D.
140 EAST 80TH STREET
NEW YORK, NEW YORK 10021
Telephone: (212) 717-1684

REGISTRATION

(PLEASE PRINT) Date:_____

NAME: LAST, FIRST			MARITAL STATUS [ ]S [ ]M [ ]D [ ]W	DATE OF BIRTH	AGE	SEX
ADDRESS: STREET	APT#	CITY	STATE	ZIP CODE	HOME PHONE ( )	
OCCUPATION:	NAME OF EMPLOYER				SOCIAL SECURITY NUMBER	
BUSINESS ADDRESS		CITY	STATE	ZIP CODE	BUSINESS PHONE ( )	
PARENT OR GUARDIAN NAME	RELATION	NAME OF SPOUSE			SOCIAL SECURITY NUMBER	
MEDICAL INSURANCE COMPANY		POLICY NUMBER				
OTHER INSURANCE		POLICY NUMBER				
HOW DID YOU HEAR ABOUT THIS OFFICE?		EMERGENCY CONTACT			PHONE NUMBER ( )	

PLEASE PROVIDE THE FOLLOWING INFORMATION

DO YOU HAVE ANY ALLERGIES? [ ] YES [ ] NO IF SO, PLEASE LIST:	REASON FOR VISIT

PLEASE LIST ALL MEDICATIONS YOU ARE NOW TAKING:

HAVE YOU HAD ANY OPERATIONS? IF SO, PLEASE DESCRIBE:

HAVE YOU BEEN TREATED FOR ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY)

[ ] ABNORMAL MOLES	[ ] CANCER	[ ] DIABETES	[ ] HEART DISEASE
[ ] MELANOMA	[ ] ARTHRITIS	[ ] HIGH BLOOD PRESSURE	[ ] LUNG DISEASE
[ ] SKIN CANCER	[ ] EXCESSIVE BLEEDING	[ ] EYE DISEASE	[ ] LIVER DISEASE
[ ] OVERGROWN SCARS	[ ] BLOOD DISORDERS	[ ] INTESTINAL DISEASE	[ ] KIDNEY DIEASE

PHARMACY NAME	PHARMACY TELEPHONE ( )	PATIENT EMAIL ADDRESS

FOR WOMEN ONLY	ARE YOU PREGNANT? [ ] YES [ ] NO	ARE YOU CURRENTLY PLANNING A PREGNANCY? [ ] YES [ ] NO	ARE YOU TAKING BIRTH CONTROL PILLS? [ ] YES [ ] NO

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____ (Name of Insurance Company) and assign directly to Dr. Andrew Woolrich all medical benefits, if any, otherwise payable to me for services 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 of benfits. I authorize the use of this signature on all my insurance submissions.

_____ _____
Signature of Insured/ Guardian Date