LARRY P. ROBERTS, M.D., P.C. 175 MEMORIAL HWY. SUITE 3-2 NEW ROCHELLE, NEW YORK 10801 (914) 235-2929

REGISTRATION FORM-WELCOME TO OUR PRACTICE!

Today's date: PCP:

PATIENT INFORMATION

Patient's last name: First: Middle: ❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms. Marital status (circle one)
Single / Mar / Div / Sep / Wid

Is this your legal name? If not, what is your legal name? (Former name): Birth date: Age: Sex:
❑ Yes ❑ No / / ❑ M ❑ F

Street address: Social Security no.: Home phone no.:
( )

P.O. box: City: State: ZIP Code:

Occupation: Employer: Employer phone no.:
( )

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. ❑ Insurance Plan ❑ Hospital
❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill: Birth date: Address (if different): Home phone no.:
/ / ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation: Employer: Employer address: Employer phone no.:
( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance ❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ [Insurance]
❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ Welfare *(Please provide coupon)* ❑ Other

Subscriber's name: Subscriber's S.S. no.: Birth date: Group no.: Policy no.: Co-payment:
/ / $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable): Subscriber's name: Group no.: Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address): Relationship to patient: Home phone no.: Work phone no.:
( ) ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*