



at Trinity Center

New Patient Demographic Form

111 Broadway, 2nd Floor
New York, NY 10006
p: (212) 263-9700
f: (212) 263-9701

Patient Information	Name (Last, First, MI)				Today's Date	
	Street Address					
	City		State	Zip	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth
	Social Security #		Daytime Phone ()		Evening Phone ()	
	Cell Phone ()			Email Address:		
	Occupation	Employer	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated			
Emergency Contact	Name				Relationship to Patient	
	Daytime Phone ()			Evening Phone ()		
Referral Info	Referring Physician's Name (if applicable)				Physician Phone/Fax (if known) () /	
	Physician Address (if known)					
	How did you hear about Trinity Center?					
Insurance Information	Primary Insurance Company		Policy #		Group #	
	Claims Address		City	State	Zip	Phone
	Patient's Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____			Name of Subscriber (if other than patient)		
	Subscriber's Social Security #			Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth
	Secondary Insurance Company		Policy #		Group #	
	Claims Address		City	State	Zip	Phone
	Patient's Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____			Name of Subscriber (if Other Than Patient)		
	Subscriber's Social Security #			Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth
Assignment and Release	Please read the following and sign below					
	<u>Assignment of Benefits and Release of Information</u> I hereby authorize my insurance benefits to be paid directly to the undersigned physician. I understand that I am financially responsible for non-covered services. I authorize the release of any medical or other information necessary to process insurance claims on my behalf.					
	<u>Medicare Patients</u> I authorize any holder of medical or other information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine benefits for this or a related Medicare claim. I request that payment of authorized Medicare benefits be made either to me or to the party who accepts assignment.					
	<u>Notice of Privacy Practices Acknowledgment</u> By signing below, I acknowledge that I have been provided a copy of the Notice of Privacy Practices.					
	Signature: _____				Date: ____ / ____ / ____	