PATIENT REGISTRATION

NEUROLOGY & SLEEP ASSOCIATES OF SUFFOLK

Rajiv B. Nanavaty, M.D. | Shubh Sharma, M.D. | Lacey D. Lyle, FNP

Patient's Name: _____ SSN:_____-_____-_____
First *Middle* *Last*

Email: _____ *Circle One* Preferred Method of Contact: Email / Home / Cell / Work

PHONE: Home _____Work: _____Cell: _____

Address:_____

City: _____ State: _____ Zip: _____

Sex: ☐ Male ☐ Female Date of Birth: _____ _____ Age: _____

Marital Status: _____ Race: _____

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Other _____

Preferred Language: _____ Employed: Full Time Part Time Retired Student

Employer: _____

Emergency Contact: _____ Relationship: _____ Phone:_____

Preferred Pharmacy: _____ Phone:_____

BILLING INFORMATION

Please provide Insurance ID # or a copy of your card to the Front Desk

Primary insurance: _____ Subscriber: _____

Relationship to subscriber: _____ Subscriber's Date of Birth: _____

Policy/ID Number: _____

Secondary insurance: _____ Subscriber: _____

Relationship to subscriber: _____ Subscriber's Date of Birth: _____

Policy/ID Number: _____

DISCLOSURE

Our *Notice of Privacy Practices* provides information about how we may use or disclose medical information about you. A copy of this policy is made available in our waiting room, you may request a copy from the Front Desk, or download a copy from our website: www.SuffolkNeuro.com

_____ I have been provided an opportunity to review the Notice of Privacy Policy.
Please Initial

In addition to the policies set forth in the Notice of Privacy Practices regarding the release of my medical information, I authorize Neurology and Sleep Associates of Suffolk to discuss my healthcare with the following individuals:

_____ _____
Name/Relationship Name/Relationship