SINAI COMMUNITY CARE
PATIENT REGISTRATION FORM

Date: _____ Prior Treatment at Sinai: ___ Yes ___ No

Name: (last, first, MI) _____

Address: _____

City, State: _____ Zip Code: _____

Phone Number: _____ Cell Phone: _____

E-mail Address: _____

Social Security#: _____ Date of Birth: _____

Marital Status: Single ___ Married ___ Separated ___ Divorced ___ Widowed ___

Patient's Maiden Name: _____

Spouse Name: _____ Spouse Date of Birth: _____

Referring Physician: _____ Phone#: _____

Physician's Address & Zip Code: _____

Primary Care Physician: _____

ADVANCE DIRECTIVES

Do you have a living will?	Yes ___ No ___
Or Medical Power of Attorney?	Yes ___ No ___
Or none of the above?	Yes ___ No ___
Would you like information on Advanced Directives?	Yes ___ No ___
Organ Donor?	Yes ___ No ___

EMPLOYMENT INFORMATION

Employer: _____

Address: _____

City, State: _____

Zip Code: _____

Occupation: _____

GUARANTOR: (IF OTHER THAN PATIENT)

Name: _____

Address: _____

City, State: _____

Zip Code: _____

Relationship to Patient: __ Spouse __ Parent __ Other

EMERGENCY CONTACT

Name: _____ Relationship: _____

Phone Number: (Other than your home number) _____

_____

Patient's Signature

( ) PROVIDED COPIES OF INSURANCE CARDS