COLON & RECTAL
SURGICAL SPECIALISTS
OF NEW YORK
www.CRSSNY.com

Dean Pappas, M.D., FACS, FASCRS
Jules Garbus, M.D., FACS, FASCRS
Steven Pelaez, M.D., FACS
Mala Murthy Balakumar, M.D., FACS

PATIENT REGISTRATION

Who are you seeing today? Please Check:

☐ **Dr. Dean Pappas** ☐ **Dr. Jules Garbus** ☐ **Dr. Steven Pelaez** ☐ **Dr. Mala Balakumar**

Last Name: _____ First: _____ Middle Initial: ____

Address: _____ City: _____ State: _____ Zip: ___

Home Ph. No. _____-_____ - _____ Cell No. _____ - _____ - _____ Work No. _____ - _____ - ____

What is your Date of Birth: ____ / ____ / ____ Age: _____

Circle One: Gender Male / Female
Marital Status: Single Married Divorced Separated Widowed

What is your current? Height: _____ Weight: _____

What is your Email Address? _____ @ _____

Who is your Family or Primary Care Physician?

Name: _____ Phone No. : _____ - _____ - ____

Address: _____

Who may we thank for this referral? Please Check:

☐ Doctor ☐Friend ☐ Family ☐Insurance Company ☐ Internet ☐ Other

If a Physician, Who is the referring Physician?

Name: _____ Phone No. : _____ - _____ - _____

Address: _____

Emergency Contact Information

Name: _____ Phone No. : _____ - _____ - _____

Address: _____
What is your relationship to the above person? _____

1100 Franklin Ave., Suite 203
Garden City, NY 11530
Tel: (516) 24S-2422 Fax: (516) 248-5162

226 N. Belle Mead Rd.,
East Setauket, NY 11733
Tel: (631) 675-0588 Fax: (516) 520-1125

Patient Name: _____

INSURANCE INFORMATION

Primary Insurance Company Name: _____ Policy#: _____

If insurance is under your spouse/parent for billing purposes, please provide:

Name: _____ Date of Birth: ___ / ___ / ____ SS#: _____ - ___ - _____

Secondary Insurance Co. Name: _____ Policy#: _____
If under spouse/parent: _____ Date of Birth: ___ / ___ / ____ SS#: _____ - ___ - _____

Third Insurance Co. Name: _____ Policy#: _____
If under spouse/parent: _____ Date of Birth: ___ / ___ / ____ SS#: _____ - ___ - _____

What is your Pharmacy Information?

Name: _____
Address: _____ Phone No. : _____ - _____ - _____

MEANINGFUL USE REQUIREMENT (government mandated):

Please check all that apply:

Race: ☐ White ☐ Hispanic ☐ American Indian ☐ Alaska Native ☐ Asian
☐ Black/African American ☐ Native Hawaiian ☐ Pacific Islander ☐ Other _____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic Preferred Language: _____

Smoking Status: ☐ Never ☐ Former- When did you quit? : _____
- ☐ Current **daily** smoker — How many packs: _____
- ☐ Current ***sometime*** smoker – Please Explain: _____

Privacy Practices Acknowledgement:

I have Read/Received the notice of privacy practice and I have been provided an opportunity to review it. Due to the HIPPA Law we are Not Allowed by Law to disclose any information pertaining to your medical condition, unless you authorize that information to be given.

INSURANCE ASSIGNMENT AND RELEASE:

I authorize the release of medical information necessary to process this claim and also authorize payment of medical benefits to the physician. I understand that it is my responsibility to present all insurance requirements to the office, i.e., insurance cards and referrals, and if I do not, I will be responsible for payment that day and will be reimbursed if I present such within 24 hours. By law, we much collect your carrier designated copay, deductible and co-insurance. Please be prepared to pay the copay at each visit. Should you not pay at the time of service and we subsequently send you a statement, a $10 charge will be added to your account. If there are reasons you cannot make your copay at each visit, arrangements MUST be made and approved in advance. Your signature below signifies your understanding and willingness to comply with this policy.

Patient Signature: _____ Date: _____ / _____ / _____