CENTRAL PARK SOUTH
OBSTETRICS AND GYNECOLOGY ASSOCIATES

RICHARD LUMIERE, M.D., F.A.C.O.G. SAMUEL RAFALIN, M.D., F.A.C.O.G JENNIFER WALSH N.P.

REGISTRATION FORM:

Have you been here before? ☐ Yes ☐ No

Patient Name:_____ Date:_____

Address:_____ APT#:_____

City:_____ State:_____ Zip:_____

Home #: (_____)_____ Work #: (_____)_____ Mobile #: (____)_____

Age:_____ Date of Birth:___/_____/_____ SS#:_____-_____-_____

Marital Status (Please check one): ☐ Single ☐ Married ☐ Divorced ☐ Widowed

How would you like to be addressed: _____ Pharmacy Phone #: (____)_____

Emergency Contact:_____ Relationship:_____

Home Phone:_____ Work Phone:_____

Insurance Information

Primary Insurance:_____ Address:_____

City:_____ State:_____ Zip:_____ Phone:_____

ID #:_____

Guarantor/Policy Holder: ☐ Self ☐ If Other, Name:_____Relation:_____

Social Security# of Policy Holder:_____ Date of Birth:_____

Secondary Insurance? ☐ Yes ☐ No Name:_____ ID:_____

Referral Information

Were you referred by a physician? Yes ☐ NO ☐ If Yes, please fill out the following info:
Name:_____ Address:_____ City:_____
State:_____ Phone:_____
If not referred by physician, how did you find us? ☐ Yellow Pages ☐ HMO Directory ☐ Website
☐ Friend/Relative ☐ Other (Please describe)_____

Guarantee of Payment/Assignment of Benefits

I hereby authorize assignment of my medical insurance payment(s) directly to Mindy Kwan, M.D./ Richard Lumiere, M.D./ Samuel Rafalin, M.D., F.A.C.O.G. for gynecological care. I understand that if for any reason, medical claims are rejected by my insurer or the insurance does not adequately cover the practice's standard fee, I shall pay the standard fees charged by Mindy Kwan, M.D./ Richard Lumiere, M.D./ Samuel Rafalin, M.D., F.A.C.O.G. I understand if for any reason my claims should go into collection status, I will be liable for any collections and/or legal fees incurred. I understand that CPS OB/GYN Associates uses third party laboratories for all diagnostic lab work and I will be held responsible for any fees incurred by third party laboratories. In addition, I am aware that CPS OB/GYN Associates has implemented a No Show/cancellation policy which requires a **24-hour notification** if I am not able to keep my scheduled appointment. I understand that if timely notice is not given, I will be subject to a $100 administrative fee.

_____ _____

Sign Date