New York Institute of Technology

ACADEMIC HEALTH CARE CENTER
Northern Blvd, Old Westbury, NY 11568
(516) 686-1300 Fax: (516) 686-7890

FAMILY HEALTH CARE CENTER
267 Carleton Ave, Central Islip, NY 11722
(631) 348-3254 Fax: (631) 348-3031

Patient Registration and Information Form

Instructions: Complete all sections that apply. Print neatly.

Today's Date: _____

How did you hear about our health center?

_____

_____

Name of the provider that referred you: _____

Patient Information	
Patient Name	Legal First Name:
	Middle Initial:
	Legal Last Name:
	Preferred Name:
Date of birth	
Age	
Patient Address	Street:
	City:
	State:
	Zip Code:
Home phone number	
Cell phone number	
Email address	

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Sex at birth	☐Male ☐Female ☐Choose not to disclose
Current Gender identity	☐Male ☐Female ☐ Transgender Male/Man Female-to-Male (FTM) ☐ Transgender Female/Woman Male-to-Female (MTF) ☐ Genderqueer ☐ Other: ☐ Choose not to disclose
Relationship Status	☐ Single ☐ Married ☐ Partnered ☐ Widowed ☐ Divorced ☐Other:
Race (optional)	
Ethnicity (optional)	
Primary language	☐ English ☐ Spanish ☐ Other:
Need a translator?	☐ Yes ☐ No
Communication concerns?	☐ No ☐ Yes – please describe:
Are you a student?	☐Yes ☐ No
	Which school do you attend?
Occupation	
Employer	Business name:
	Business address:
	Business phone #:

Emergency contact	
Relationship to patient	☐ Self ☐ Spouse ☐ Partner ☐ Parent ☐ Other:
Name of contact	First Name:
	Last Name:
Phone number	
Address	Street:
	City:
	State:
	Zip Code:

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Person responsible for Account (Insurance holder):	
Relationship to patient	☐ Self ☐ Spouse ☐ Partner ☐ Parent ☐ Other:
Name of person responsible for account	First Name:
	Middle Initial:
	Last Name:
Date of birth	
Home Address	Street:
	City:
	State:
	Zip Code:
Employer of person responsible for account	Business name:
	Business address:
	Business phone #:

Insurance information	
Primary insurance	
Policy #	
Group #	
Address	
Secondary insurance	
Policy #	
Group #	
Address	

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Primary Care Physician (PCP)	
Primary care physician	☐ DO ☐ MD
	First Name:
	Last Name:
Phone number	
Fax number	
PCP Address	Street:
	City:
	State:
	Zip Code:

Pharmacy	
Pharmacy name	
Phone number	
Fax number	
Pharmacy Address	Street:
	City:
	State:
	Zip Code:

Name of person completing this form	Legal First Name:
	Middle Initial:
	Legal Last Name:
Relationship to patient	☐ Self ☐ Spouse ☐ Partner ☐ Parent ☐ Other:
Signature	