10 Chester Avenue, White Plains, NY 10601
(914) 448-1000

Registration Form

Patient Information

Name: ____Male____ Female ____ Date of Birth: _____________

Social Security Number: ________________ Email: ____

Home Phone: (___) _____________ Cell Phone (___) ______________Work Phone (____) ______________

Address: ________________________________City: _________________State: ______ Zip: _____________

How did you hear about us? ______________Primary MD: ________________Phone __________________

Please contact in case of emergency: ___________________________ Phone: _________________________

Reason for today's visit: ____

Pharmacy Name: _________________________ Pharmacy Phone: ___________________________________

Primary Insurance Information

Name of Insured: ______________________DOB: ______________ Relationship to Patient: _____________

SS#: _______________ Name of Employer: __________________ Work Phone: (____) _________________

Address of Employer: __________________________ City: _____________State: ____ Zip: ______________

Insurance Company: ______________________ Group # ______________ ID # ________________________

Ins Co Address: _______________________________________Ins Co Phone: ___________________________

Secondary Insurance Information

Name of Insured: ______________________DOB: ______________ Relationship to Patient: _____________

SS#: _______________ Name of Employer: __________________ Work Phone: (____) _________________

Address of Employer: __________________________ City: _____________State: ____ Zip: ______________

Insurance Company: ______________________ Group # ______________ ID # ________________________

Ins Co Address: _______________________________________Ins Co Phone: ___________________________

I authorize payment of medical benefits for any services provided to me by White Plains Walk-in Medical Care. I understand that I am financially responsible for any amount not covered by insurance. I authorize release of information concerning my health care to my billing agent and insurance company for the purpose of reviewing and processing medical claims for payment. I certify that all the information provided above is accurate and true.

Signature: (Patient or guarding if patient is minor)__________________________________Date ____________