Welcome! Pedre Integrative Health

Vincent M. Pedre, MD, PLLC
120 E. 56th St., Suite 530, New York, NY 10022
TEL (212) 860-8300; FAX (212) 230-1828

REGISTRATION FORM (PLEASE PRINT CLEARLY)

NAME: ____________________, ________________________ (LAST / FIRST / M.I.) BIRTHDATE: ______________
MALE: _____ FEMALE: ______

STREET: ____ APT #: ________________

CITY: ________________________ STATE: ________ ZIP CODE: ______________

HOME TEL #: ____________________ DAYTIME TEL #: __________________

CELLPHONE #: ____________________ EMAIL ADDRESS: ____________________________

OCCUPATION: ____________________ SS #: ______________________________

EMPLOYED BY: ____________________________________ EMPLOYER TEL #: ________

IN CASE OF EMERGENCY PLEASE NOTIFY: ____

RELATIONSHIP: ____________________ TEL #: ____________________________

HOW DID YOU HEAR ABOUT US? ____

WHO REFERRED YOU TO US? ____

INSURED NAME (IF NOT SAME AS ABOVE): ______________________________________

STREET: ____ APT #: ________________

CITY: ________________________ STATE: ________ ZIP CODE: ______________

PATIENT'S RELATIONSHIP TO INSURED (CIRCLE ONE): SELF SPOUSE CHILD OTHER

MEDICARE? YES _____ NO ______ IF YES, NUMBER: ____________________________

PRIMARY INSURANCE: ____________________________________

POLICY NUMBER : __________________________ GROUP NUMBER: ________________

PHARMACY BENEFITS ADMINISTRATOR: ________________ _ TEL NUMBER: ______________

YOUR PREFERRED PHARMACY: ______________, ____________________________( )____-______
(name) (address) (number)

SECONDARY INSURANCE*: ____________________________________

2ndry POLICY NUMBER*: ________________________ GROUP NUMBER*: ________________
(* if applicable)

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administrations or their intermediaries or carriers, or to the billing agent of this physician, any information needed for this or a related medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignments.

SIGNATURE: __________________________________ DATE: ________________________

PAYMENT IS REQUESTED AT THE TIME OF VISIT

PATIENT ACKNOWLEDGMENT OF
RECEIPT OF
NOTICE OF PRIVACY PRACTICES
FOR PROTECTED HEALTH INFORMATION
AND CANCELLATION POLICY

PLEASE COMPLETE AND SIGN BELOW:

I HAVE RECEIVED, READ AND ACKNOWLEDGE THAT I UNDERSTAND THE NOTICE OF PRIVACY PRACTICES AND THE CANCELLATION POLICY FOR PEDRE INTEGRATIVE HEALTH:

Further, I give permission to the doctors and/or their authorized representatives at 120 E. 56th Street to communicate test results and other private medical information with myself via the following: (Please indicate yes or no for the following)

Yes ☐ No ☐ Secure voicemail/ answering machine: (_____) ______ - ___________
(Your private cell phone number is best and preferred for the above)

Yes ☐ No ☐ Secure fax number: (_____) ______ - _____________

Yes ☐ No ☐ Secure email: ____

Yes ☐ No ☐ Other: ____

Also, by signing this form I give permission to the doctors and/or their authorized representatives at 120 E. 56th Street to communicate pertinent healthcare information with other healthcare professionals or medical facilities as deemed appropriate for my medical care.

PRINT NAME: ____

SIGNATURE: ____

DATE: _________________

FAX FORMS BACK VIA OUR SECURE FAX LINE: 212-230-1828