Lung Transplant Program - New York Presbyterian Hospital of Columbia University Medical Center

PATIENT REGISTRATION FORM

Please complete this form, filling ***each*** item. All information is strictly confidential

Intake Date: _____

Patient being referred for: □Lung TXP □Heart / Lung TXP
□Consultation (pt does not warrant or not considering lung transplant)

PATIENT INFORMATION

PLEASE PRINT CLEARLY

Patient Diagnosis: _____

Patient Name: _____ Date of Birth: _____ Gender: □Male □Female Age: _____

Street Address: _____

Marital Status: □Single □Mar □Div □Widow Primary Language: _____ Email: _____

Social Security #: _____ Home Telephone: _____ Cell # _____

Mother's First Name: _____ Father's First Name: _____

EMERGENCY CONTACT

Name _____Contact#: _____ Relation: □Spouse □Parent □Son □Daughter □Other

INSURANCE INFORMATION

Copy of insurance card required

Primary Insurance: _____ □EPO □HMO □PPO □OTHER_____

Policy Number: _____ Group Number: _____

Subscriber's name: _____ Subscriber's S.S # _____D.O.B.:_____

Relation to patient: □self □spouse □child □other _____ Home Telephone: _____

IF MEDICARE IS PRIMARY PATIENT MUST HAVE A SECONDARY INSURANCE

Secondary Insurance: _____ □EPO □HMO □PPO □OTHER_____

Policy Number: _____ Group Number: _____

Subscriber's name: _____ Subscriber's S.S # _____D.O.B.:_____

Relation to patient: □self □spouse □child □other _____ Home Telephone: _____

OFFICE POLICY: IT IS THE PATIENT'S RESPONSIBILITY TO PROVIDE HIS/HER INSURANCE CARD AND TO NOTIFY US OF ALL CHANGES IN COVERAGE.

REFERRING PHYSICIAN INFORMATION

Doctor: _____ Practice Name: _____

Street Address: _____

Office Phone: _____ Office Fax: _____ UPIN: _____

DEA# _____ License #: _____ NPI #: _____

PLEASE LIST ANY OTHER PHYSICIANS INVOLVED IN PATIENT CARE:

Doctor_____ Office Phone: _____Office Fax: _____