Hudson Valley Fertility
Daniel Levine, M.D.
Patient Registration Form

Please Print ***Date_____***

Name:_____ Sex___F ____M SS#_____
Address:_____City_____Zip_____
Phone_____ Cell Phone_____ Age_____ DOB _____
Marital Status: Single_____ Married____ Divorced/Separated_____ Widow/Widower_____
Patients Employer_____ Occupation_____
Employers Address_____Work Phone_____
Emergency Contact_____ Phone _____
Spouse/Significant Others Name_____
Spouse/Significant Others DOB:_____ SS#_____
Spouse's/Significant Others Employer _____ Occupation_____
Employers Address _____Work Phone_____
Pharmacy Name & Address_____ Pharmacy Phone #_____

INSURANCE INFORMATION

Primary Insurance Company:_____
Subscriber Name:_____ ID#:_____
SS#:_____ DOB:_____
Secondary Insurance Company.:_____
Subscriber Name:_____ ID#:_____
SS#:_____ DOB:_____

HIPAA DOCUMENTATION
(Please answer all questions below and then sign and date)

1 I acknowledge that I have been given the opportunity to read and/or receive a copy of Hudson Valley Fertility's Privacy Notice. Y N

2. Leave appointment message on:
   - Answering Machine ? Y N
   - Office Voice Mail ? Y N
   - w/ Person Listed Below ? Y N

   Leave other medical info on:
   - Answering Machine ? Y N
   - Office Voice Mail ? Y N
   - w/ Person Listed Below? Y N

3. Person(s) authorized to Discuss the Above & relationship

_____ _____

_____ _____

Signature_____ Date_____

*** I consent to have the Practice use and disclose my protected health information for payment, treatment and health care operations purposes, and for such other purposes that are permitted under HIPAA or other federal or state law without my written authorization.

Signature_____ Date_____

*** I authorize the payment of medical benefits to above stated physician or supplier for services rendered.

Signature_____ Date_____