PATIENT REGISTRATION FORM.		Today's Date:	
Please complete all questions if applicable, use N/A if not applicable			
Last Name:	First:		Initial
Last 4 digits SS:	Date of Birth:		Sex:
Address:	City:	State:	Zip:
Address:			
Phone Cell:	Home/Other Phone:		
Email:			
Primary Care Physician:		Referring Physician:	
Preferred Pharmacy:		City/State/Phone	
If patient under 18, indicate Legal Guardian:			
Guardian DOB:		Relationship to patient:	
IF EXACT DATE UNKNOWN GIVE BEST ANSWER:			
Date of Last Mammogram: (if applicable)			
Date of Last Colonoscopy: (if applicable)			
Date of last Flu shot:			
Date of last Pneumovax: (patients 65 and over)			

I, the undersigned, hereby certify that I have Insurance coverage and assign all insurance benefits to Westchester Health Associates, if any, for services rendered. I understand that I am responsible for all co-payments/co-insurance, deductibles and otherwise elective non-covered services provided to me (or my dependents). I authorize the use of this signature on all insurance submissions. I, the undersigned, hereby agree that I am financially responsible for all services provided to me by Westchester Health.

Signature _____Date_____