Malik E. McKany, MD
PATIENT REGISTRATION FORM
(please print)

Today's Date: _____ **Primary Doctor: _____**

Patient's Name: _____ DOB: _____ Age: _____

Street Address: _____ SS#: _____ Sex: (circle one) M F

City: _____State: _____ Zip: _____ Spouse/parent name: _____

Home Phone: _____ Cell #: _____ Work Phone:_____

Occupation: _____ Employer: _____

May we contact you at? (circle) Home Cell Work Other: _____

Marital Status (circle one): S M D W

Race: _____ Ethnicity: _____ Preferred Language: _____

Reason for your visit today: _____ Referred by: _____

Is the reason for your visit related to a work injury or an auto accident? (circle one) Y N

E-mail address: _____ @ _____
Your e-mail will only be used to grant you access to our patient portal. We will not give out your e-mail to anyone for any reason or use it for any other purpose.

INSURANCE INFORMATION

Primary Insurance: (circle one) BCBS BCN Medicare HAP Medicare Advantage Plan

Health Plus HAP Priority Health Medicaid _____ Commercial/other:_____

Primary Insured Name: _____ DOB: _____

Secondary Insurance Name: _____

Secondary Insurance Subscriber Name: _____ DOB: _____

Pharmacy Name/Phone#: _____

Emergency Contact

Name: _____ Phone#: _____

The above information is true to the best of my knowledge. I authorized my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any patient balance. I also authorize Malik E. McKany, MD or the insurance company to release any information required to process my claims. **** All office visit co-pays are collected at the time of service. All deductible and co-insurance amounts are collected prior to any scheduled surgery.**

_____ _____

Patient/Guardian Signature Date