Ihor Magun M.D.
2000 North Village Avenue Suite 202
Rockville Centre, NY 11570
Telephone: (516) 766-5147 Fax: (516) 766-5483

Patient Registration Form

Patient's Name _____
(Last) (First) (MI)

Address _____

City _____ **State** _____ **Zip** _____

Cell Phone _____ **E-mail** _____

Date of Birth _____ **Age** _____ **Sex** _____

Marital Status ___ **Single** ___**Married** ___**Divorced** ___**Widowed**

Patient's Social Security Number _____

Patient's Occupation _____ **Employer's Phone** _____

Employer's Address _____

Name of Primary Insurer _____ **Secondary Insurer** _____

I.D. Number _____

Mail Order Pharmacy Name _____

Local Pharmacy Name & Number _____

Emergency Contact _____ **Phone Number** _____

Relationship to Patient _____

Assignment & Release: I, the undersigned, have insurance coverage with _____, and assign, directly to Dr. Ihor Magun all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I herby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature _____ **Date** _____