CareMed
Primary & Urgent Care
266 Middle Country Road, Coram NY 11727 Ph.: 631-698-1111

New Patient Registration Form

Name:_____
First Middle . Last

Date of Birth: _____ SS #: _____

Material Status: Single Gender: Male ○ Female ◉

Parent/Guardian Name(s)
For Patient Under 18 Years of Age: _____

_____
Address: Street City State Zip Code

_____ _____ _____
Home Phone Work Phone Cell Phone

_____ _____ _____
Email Pharmacy Name Town

_____ _____ _____ _____
Pref. Communication Ethnicity Race Pref. Language

Can leave Voice Mail (circle): ☐ Home ☐ Work ☐ Cell

Emergency Contact:

Name: _____ Phone: _____ Relation: _____

If you would like someone other than yourself and your medical provider to have access to your medical information, please list him/her here:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

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Insurance Information

Primary Insurance: _____Policy Holder: _____

Policy Holder's Relationship to Patient: _____

Policy Holder's address (if different): _____

Policy ID: _____Group No. _____

Policy Holder's Employer: _____ Phone: _____

Policy Holder's Employer's Address: _____

Policy Holder's S.S.N.: _____Policy Holder's Date of Birth: _____

Secondary Insurance Information (if applicable):

Insurance: _____Policy Holder: _____

Policy Holder's Relationship to Patient: _____

Policy Holder's address (if different): _____

Policy ID: _____Group No. _____

Policy Holder's Employer: _____ Phone: _____

Policy Holder's Employer's Address: _____

Policy Holder's S.S.N.: _____Policy Holder's Date of Birth: _____

_____ _____

Signature of Patient or Legal Guardian Date