North Shore Medical Arts, LLP

A Medical Practice Specializing in Pulmonary, Critical Care and Sleep Medicine

295 COMMUNITY DRIVE
GREAT NECK, NEW YORK 11021
Phone (516) 504-0800 • Fax (516) 504-0824

Sanford M. Ratner, M.D. Joseph Genovese, D.O. Jill Karpel, M.D.

REGISTRATION FORM

LAST NAME _____ FIRST NAME _____ MI__

STREET _____ CITY _____

STATE _____ ZIP _____

HOME PHONE _____ CELL _____ WORK _____

DATE of BIRTH _____ AGE _____ SS# _____

MALE	FEMALE	SINGLE	MARRIED	DIVORCED	WIDOWED

OCCUPATION _____ EMPLOYER _____

EMPLOYER ADDRESS _____

EMPLOYER PHONE _____

IN CASE OF EMERGENCY, PLEASE CONTACT: _____

RELATIONSHIP TO SELF _____ PHONE _____

(PLEASE GIVE INSURANCE CARD TO FRONT DESK)

I authorize any holder of medical or other information about me to release to the Social Security Administration and Healthcare Financing Administrations or their intermediaries or carriers, or to the billing agent of this physician, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

I authorize this office to furnish my Insurance carriers with any information relevant to my claim to make direct payment when accepted.

Signed _____ Date _____

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HIPPA (MEDICAL RELEASE OF INFORMATION)

PATIENT NAME: _____

DATE OF BIRTH: _____

I HEREBY GIVE AUTHORIZATION TO SANFORD RATNER, M.D., JOSEPH GENOVESE, D.O., AND JILL KARPEL, M.D., TO RECEIVE AND DISCLOSE ANY HEALTH INFORMATION AND/OR RECORDS PERTAINING TO MY CARE.

I ALSO GIVE THE ABOVE PHYSICIANS AUTHORIZATION TO DISCUSS MY HEALTH INFORMATION WITH THE FOLLOWING FAMILY MEMBER(S), DOCTOR(S) OR OTHER INDIVIDUALS.

1.

2.

3.

4.

I ACKNOWLEDGE RECEIVING A COPY OF THIS NORTH SHORE MEDICAL ARTS PATIENT PRIVACY ACT.

SIGNATURE: _____ **DATE:** _____

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Dear Patient,

To expedite any prescriptions ordered by your Physician, please fill out this form so that we can add your pharmacy to your medical record file.

Thank you

Patient Name_____ **DOB**_____/_____/_____

Name of Pharmacy_____

Address_____

Phone_____ **Fax**_____

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Patient Portal Authorization

Please complete this form if you would like to access web-enable patient portal

Patient Information (Please Print):

Name: _____ Date of Birth: _____

Email address: _____

I understand that the Patient Portal is not intended to provide internet based diagnostic medical services and should not be used for emergent communication. In the event of an emergency, please call 911 or visit the nearest emergency room.
I am aware that the information being published will include appointment information, current medications, lab and diagnostic imaging results, referrals, and personal health information such as allergies, immunizations, problems, and vitals. And I will now receive emails as appointments are made or modified, labs and diagnostic imaging are posted to the portal, and as new messages arrive in your portal inbox.
By signing below, you agree to become web-enabled for the Patient Portal.

_____ _____

Patient Signature Today's Date