Hemophilia Center OF WESTERN NEW YORK

936 DELAWARE AVENUE SUITE 300
BUFFALO, NEW YORK 14209

PATIENT REGISTRATION
PLEASE PRINT

Name:_____
Last First

DOB:_____ **Gender (please circle):** Male Female

Race:
American Indian or Alaska Native
Asian
Black or African American
Native Hawaiian or other Pacific Island
White
Other Race
Declined

Ethnic Group:
Hispanic or Latino
Non-Hispanic or Latino
Declined

Preferred Language: _____

Address:_____
STREET CITY STATE ZIP

Phone:_____ **Cell:**_____ **Work:**_____

E-Mail: _____

Parent/Guardian or Significant Other:_____ **(If applicable)**

INSURANCE INFORMATION	PRIMARY INSURANCE	SECONDARY INSURANCE
NAME		
ID#		
SUBSCRIBER'S NAME		
SUBSCRIBER'S DOB		
EMPLOYER		
ADDRESS		
PHONE #		

Hemophilia Center
OF WESTERN NEW YORK

EMERGENCY INFORMATION

Local Emergency Contact

Name: _____

Phone Number(s):_____

Relationship: _____

Out of Area Emergency Contact

Name:_____

Phone Number(s):_____

Relationship:_____

The Hemophilia Center of Western New York, Inc. will submit a bill to the insurance provider (s) that you have indicated.

I authorize the release of any pertinent medical information necessary to determine liability for payment and to obtain reimbursement of any claim to insurance carriers.

I understand that I am financially responsible to the Hemophilia Center of Western New York, Inc. for all charges. I am responsible for all deductibles, co-payments, and must remit to the Hemophilia Center of Western New York, Inc. all payments made to me by my insurance company/companies.

Signature _____ **Date** _____