



**Echo Specialty Pharmacy Services**  
**www.echomed.com**

**Patient Registration Form**

**Transplant Department**  
 Tel: (718) 391-0400 • Fax: (718) 391-0777

**Biologics Department**  
 Tel: (718) 247-4615 • Fax: (718) 391-0446

**Oncology Department**  
 Tel: (718) 247-4615 • Fax: (718) 391-0446

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

PCP: \_\_\_\_\_

**PATIENT INFORMATION**

Patient's last name:	First name:	MI:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status: Single <input type="checkbox"/> Mar <input type="checkbox"/> Div <input type="checkbox"/> Sep <input type="checkbox"/> Wid <input type="checkbox"/>
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Date of Birth: ____/____/____	Social Security # : ____-____-____	Home phone no.: ( ) _____	Age: _____	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
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Street address:	Cell Phone No.: _____	Work Phone No.: _____
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Apt. # :	P.O. Box # :	City:	State:
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*Please indicate your **PRIMARY** insurance below.* (Copies of all insurance cards-front and back-must be provided)

Please print name of **PRIMARY** insurance (Please indicate HMO, PPO, SUPPLEMENTAL, etc. if applicable):

Subscriber's name (if NOT the patient):	Subscriber's Social Security #: ____-____-____	Date of Birth: ____/____/____
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Group #:	Policy #:
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Patient's relationship to subscriber:  Self  Spouse  Child  Other (*Please specify*):

*Please provide **SECONDARY** insurance information below:*

Please print name of **SECONDARY** insurance (Please indicate HMO, PPO, SUPPLEMENTAL, etc. if applicable):

Subscriber's name (if NOT the patient):	Subscriber's Social Security #: ____-____-____	Date of Birth: ____/____/____
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Group #:	Policy #:
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Patient's relationship to subscriber:  Self  Spouse  Child  Other Please specify:

**Important:** Does your Secondary insurer coordinate benefits with Medicare?  YES  NO

**PRESCRIBING PHYSICIAN INFORMATION**

Physician Name:	Phone no.: ( ) _____	Fax no.: ( ) _____
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Address:	City:	ST:	Zip:
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State License#:	Tax ID# (9 Digits):
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DEA # (2 Letters & 7 Digits):	NPI #:
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**PATIENT SIGNATURE**

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the provider. I understand that I am financially responsible for any balance. I also authorize Echo Pharmacy or the insurance company or companies to release any information required to process my claims.

*Patient/Guardian signature:* \_\_\_\_\_ *Date:* \_\_\_\_\_

*Print Name:* \_\_\_\_\_