Greenwich Health, PLLC
Julie Huang-Lionnet, MD
1472 Post Road, Darien, CT 06820
P: 203.900-3996 or 203.900.3995

Board Certified Anesthesiology
Subspecialty Certification in Interventional Pain Management
Certified in Venous, Regenerative and Cosmetic Medicine
F: 203.900.3998 or 203.902-0166 ▪ www.greenwichhealth.org

PATIENT REGISTRATION

PATIENT INFORMATION

Patient Last Name: ________________________ **First Name:** _______________________ **Middle Name:** ___________________________

Gender: ☐ Male ☐ Female **DOB:** _____/_____/_____ **Age:** _____ **Marital Status:** ☐ M ☐ S ☐ W ☐ D

RACE: ☐ American Indian ☐ Asian ☐ Black or African American ☐ Hispanic ☐ Hawaiian ☐ White
☐ Refuse to report ☐ Other: ___________

ETHNICITY: ☐ Hispanic or Latina ☐ Non-Hispanic or Latino ☐ Refuse to report

LANGUAGE: ☐ English ☐ French ☐ German ☐ Japanese ☐ Mandarin ☐ Russian ☐ Spanish ☐ Other: ___________

Social Security#: ________-______-________ **Driver's License#:** ___________________ **Mother's Maiden Name:** ___________________

Home Address: ____
City State Zip Code

Home Phone #: (_________) _________________________ Cell/Message Phone: (_________) _________________________________

Work Phone #: (_________) _________________________ Email: ____

PHYSICIAN / EMPLOYMENT INFORMATION

Primary Care Physician: ______________________________ Work Phone: (_______)_______________ Fax: (_______)_______________

Work Address: ____
City State Zip Code

Referring Physician (if different): ___________________________ Work Phone: (______)______________ Fax: (______)______________

Work Address: ____
City State Zip Code

PATIENT EMPLOYER: ___________________________________ Work Phone: (_______)_______________ Fax: (_______)_______________

Work Address: ____
City State Zip Code

Occupation: ____

PHARMACY: _________________________________ ADDRESS: ____
City State Zip Code

EMERGENCY CONTACT: ________________________RELATIONSHIP:_______________ Phone #: (________) _______________________

Nearest friend or relative not living with you, in case of emergency▼ **EMAIL ADDRESS:** __________________________________

INSURANCE-PRIMARY

Name of Insurance: ___________________________ ID#: _______________________________ Group: ________________________

Insured's Name: _____________________________________ Insured's Date of Birth: ______/______/______ Relationship: ____________

Insured's Social Security #: ______-____-______ Insurance Phone #: (_________)_________________

Employer's Name: ____________________________ Employer Address: ____
City State Zip Code

INSURANCE-SECONDARY

Name of Insurance: ___________________________ ID#: _______________________________ Group: ________________________

Insured's Name: _____________________________________ Insured's Date of Birth: ______/______/______ Relationship: ____________

Insured's Social Security #: ______-____-______ Insurance Phone #: (_________)_________________

Employer's Name: ____________________________ Employer Address: ____
City State Zip Code

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PATIENT REGISTRATION (Page Two)

Patient Name: ____ **DATE:** ______/______/______

WORKER'S COMPENSATION

Employer Name: ____ Date of Injury: _______________ Claim#: ____________________

Insurance Company: _________________________________ Insurance Company Phone #: (________) _______________

Claim Address: ____
City State Zip Code

Adjuster's Name: ____ Phone #: (___________)_________________________

Attorney's Name: ____ Phone #: (___________)_________________________

LEARNING ABOUT GREENWICH HEALTH

How were you referred to us?

☐ Physician ☐ Surgery ☐ Neurology ☐ Hospital ☐ Urgent Care ☐ Chiropractor ☐ Acupuncture

☐ Podiatry ☐ Radiology ☐ Google ☐ Webpage ☐ Linked-In ☐ Doximity ☐ Social Media

☐ Insurance ☐ ZocDoc ☐ Yelp ☐ Newspaper ☐ Print Media ☐ Magazine ☐ Community Mailing

☐ Friend ☐ Family ☐ Work ☐ Other___________________

AUTHORIZATION FOR PAYMENT AND RELEASE OF INFORMATION: I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO DETERMINE MY BENEFITS AND TO PROCESS ANY CLAIM FOR REIMBURSEMENT OF FEES CHARGED TO ME FOR MEDICAL SERVICES AND TREATMENT PROVIDED AT GREENWICH HEALTH, PLLC. I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO GREENWICH HEALTH, PLLC OR TO JULIE HUANG-LIONNET, MD. I AM FINANCIALLY RESPONSIBLE FOR ALL NON-COVERED SERVICES. FURTHER DETAILS AS SIGNED PER GREENWICH HEALTH PLLC'S PAYMENT POLICY (ATTACHED). I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL.

Patient Signature: _____________________________________ Date: __________________________
(or Legal Representative)

AUTHORIZATION OF BENEFITS: I HEREBY AUTHORIZE GREENWICH HEALTH, PLLC TO APPLY FOR BENEFITS ON MY BEHALF FOR COVERED SERVICES RENDERED. I REQUEST THAT PAYMENT FROM CMS OR MY INSURANCE CARRIER TO FORWARD PAYMENT FOR MEDICAL BENEFITS FOR ALL SERVICES BE MADE DIRECTLY TO GREENWICH HEALTH, PLLC OR TO JULIE HUANG-LIONNET, MD.

I CERTIFY THAT THE INFORMATION I HAVE PROVIDED WITH REGARDS TO MY INSURANCE COVERAGE IS CORRECT. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL.

Patient Signature: _____________________________________ Date: __________________________
(or Legal Representative)