

# PATIENT REGISTRATION

Referring Physician: \_\_\_\_\_  
Referring MD Phone #: \_\_\_\_\_

PATIENT NUMBER: \_\_\_\_\_

NAME (Last, First, MI) \_\_\_\_\_ SEX M F  
Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ SS #: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Mail Address (If Different): \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone #: \_\_\_\_\_ Cell #: \_\_\_\_\_ E-Mail: \_\_\_\_\_ Marital Status: \_\_\_\_\_  
Employer: \_\_\_\_\_ Address: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Spouse/Parent/Guardian Name: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Parents Employer: Mother: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Father: \_\_\_\_\_ Phone #: \_\_\_\_\_

IN CASE OF EMERGENCY CONTACT: NAME: \_\_\_\_\_ Phone #: \_\_\_\_\_

Have you previously been treated by any of these physicians : (CIRCLE)  
Dr. Blyznak, Dr. Dubrow, Dr. Hanypsiak, Dr. Hindes, Dr. Kurtz, Dr. Muhlrاد  
Dr. Oliveto, Dr. Patel, Dr. Petraco, Dr. Puopolo, Dr. Schrank

## PRIMARY INSURANCE

Insurance Company: \_\_\_\_\_  
Insurance Company Address: \_\_\_\_\_  
Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_  
**PERSON RESPONSIBLE FOR ACCOUNT:** Last: \_\_\_\_\_ First: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Insured's Employer: \_\_\_\_\_  
Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_ ID #: \_\_\_\_\_

## OTHER INSURANCE

Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Insurance Company Address: \_\_\_\_\_  
Insured Name: Last: \_\_\_\_\_ First: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Employer: \_\_\_\_\_ Business Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SS #: \_\_\_\_\_  
**FOR MEDICARE PATIENTS: IS THIS A MEDIGAP? YES: \_\_\_\_\_ NO: \_\_\_\_\_**

WAS THIS INJURY RELATED TO EMPLOYMENT, A MOTOR VEHICLE ACCIDENT, SCHOOL INJURY (OR OTHER LIABILITY) \_\_\_\_\_

WHERE DID INJURY OCCUR? DESCRIBE CIRCUMSTANCES OF INJURY: (DATE, LOCATION, HOW DID IT HAPPEN?) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

ARE YOU PURSUING LEGAL ACTION? \_\_\_\_\_

**Assignment of Benefits:** I irrevocably assign/authorize to Dr. \_\_\_\_\_ the following: a: all of my rights and benefits under Medicare or any insurance contracts for payment of services rendered to me by him, b: all information regarding my benefits under any insurance policy relating to his claims to be released to him, c: to file insurance claims on my behalf including Medigap, if applicable for services rendered to me, d: direct that all such payments go directly to him, e: to act in my behalf and report any suspected violations of proper claims practices to the proper regulatory authorities, f: I authorize the provider to release any information necessary to substantiate a claim. Any questions I may have concerning this assignment of benefits has been explained to my full satisfaction, and I understand its nature and effect.

PATIENTS SIGNATURE (If minor, parent or guardian) \_\_\_\_\_

DATE \_\_\_\_\_

Checked By: \_\_\_\_\_ Date: \_\_\_\_\_