

PATIENT REGISTRATION

Referring MD: _____
Referring MD Phone #: _____
Family MD: _____

PATIENT NUMBER: _____

NAME(Last/First,MI) _____
DateofBirth: _____ Age: _____ SS# _____ Occupation: _____
Street Address: _____ City: _____ St: _____ Zip: _____
Mail Address (If Different) _____ City: _____ St: _____ Zip: _____
Phone #: _____ Sex: M/T _____ 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 BEEN PREVIOUSLY TREATED BY ANY OF THESE PHYSICIANS: (CIRCLE)
Dr. Blyznak, Dr. Dubrow, Dr. Hines, Dr. Kurtz, Dr. Levin, Dr. Muhlrاد, Dr. Oliveto, Dr. Schrank,
Dr. Petraco

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 ACTIONS?

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 for 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 question I may have concerning
this assignment of benefits has been explained to my full satisfaction, and I understand its nature and effect.

Patient Signature(if minor, parent or guardian)

DATE

Checked by: _____ Date: _____

