

## PATIENT REGISTRATION FORM

Patient Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Patient Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Patient Sex: M F Employed: Y N Employer Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Marital Status: S M W D Number of Insurance Policies: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

## INSURANCE INFORMATION

Primary Insurance Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Group Name or #: \_\_\_\_\_ Effective Date: \_\_\_\_\_ ID# \_\_\_\_\_

Secondary Insurance Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Group Name or #: \_\_\_\_\_ Effective Date: \_\_\_\_\_ ID# \_\_\_\_\_

Tertiary Insurance Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Group Name or #: \_\_\_\_\_ Effective Date: \_\_\_\_\_ ID# \_\_\_\_\_

Spouse's Name (if applicable): \_\_\_\_\_ Spouse's DOB: \_\_\_\_\_

Nearest Living Relative / Friend not living with you: \_\_\_\_\_

Relationship to above: \_\_\_\_\_ Phone: \_\_\_\_\_

If necessary, did you obtain a referral for this visit? Y N

I authorize the release of medical information necessary to process claims for medical benefits. I assign the benefits payable to which I am entitled including Medicare, private insurance and other health insurance to JACOB ZAMSTEIN, MD, LLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I realize that insurance is considered a method of reimbursing the patient for fees paid to the doctor and not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. I understand that I am financially responsible for all charges whether or not paid by my insurance including all reasonable costs, expenses, including court and attorney's fees incurred in pursuing collection of such charges.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_