REGISTRATION FORM

Please Print

NAME _____
Last First Middle

STREET _____ E-MAIL ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

PHONE NO. _____ CELL NO. _____ WORK NO. _____

DATE OF BIRTH _____ SOCIAL SECURITY # _____ SEX: ❑ F ❑ M

❑ MARRIED ❑ SINGLE ❑ DIVORCED ❑ WIDOWED SPOUSE/SIGNIFICANT OTHER'S NAME _____

REFERRING /PRIMARY PHYSICIAN _____ PHONE # _____

ADDRESS _____

EMPLOYER'S NAME _____ PHONE # _____

EMPLOYER'S ADDRESS _____ OCCUPATION _____

IN CASE OF EMERGENCY, NOTIFY _____

RELATIONSHIP _____ TELEPHONE: Home _____ Work _____

FOR WOMEN ONLY:

GYNECOLOGIST NAME _____ PHONE # _____

ADDRESS _____

PRIMARY INSURANCE _____

POLICY HOLDER NAME _____ SOCIAL SECURITY # _____

PATIENT RELATIONSHIP TO INSURED: ❑ SELF ❑ SPOUSE ❑ CHILD ❑ OTHER

POLICY HOLDER DATE OF BIRTH _____ POLICY NO. _____ GROUP NO. _____

SECONDARY INSURANCE _____

POLICY HOLDER NAME _____ SOCIAL SECURITY # _____

PATIENT RELATIONSHIP TO INSURED: ❑ SELF ❑ SPOUSE ❑ CHILD ❑ OTHER

POLICY HOLDER DATE OF BIRTH _____ POLICY NO. _____ GROUP NO. _____

PHARMACY NAME _____ **PHARMACY PHONE NO.** _____

MAY WE LEAVE A MESSAGE ❑ AT HOME ❑ ANSWERING MACHINE ❑ AT WORK ❑ CELL PHONE

I WILL BE PAYING TODAY BY: ❑ CASH ❑ CHECK ❑ CREDIT CARD

I authorize any holder of medical or other information about me to release to the Social Security Administration and the Centers for Medicare and Medicaid Services or its intermediaries or carriers, or to the billing agent of this physician, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

I request that payment of authorized Medigap benefits be made either to me or on my behalf to the provider of service and (or) supplier for any services furnished to me by the provider of service and (or) supplier. I authorize any holder of Medicare information about me to release to my Medigap insurance, _____, any information needed to determine these benefits payable for related services. HIC# _____

SIGNED: _____ DATE: _____