

REGISTRATION INFORMATION

(PLEASE PRINT)

Date _____

Home Phone# _____

Patient _____
Last Name First Name Initial

Responsible Party (if a minor) _____

Street Address _____

City _____ State _____ Zip _____

Sex M F Age _____ Birthdate _____ Single Married Widowed Separated Divorced

Preferred Language _____ Race _____ Ethnicity (circle) : Hispanic or Non-Hispanic

Employed Full-Time Student Part-Time Student Patient's School Name _____

Patient Employed By _____

Business Address _____

Occupation _____ Business Phone _____

Spouse (or responsible party) Name _____ Birthdate _____

Business Name & Address _____

Occupation _____ Business Phone _____

Who is responsible for this account? _____ Relationship to Patient _____

Social Security # _____ Spouse's Social Security # _____

*In case of emergency, who should be notified? _____

Phone _____ Relationship to patient _____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage and assign directly to Dr. Kenneth Sobel all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic. I further agree that I am responsible for all court costs, collection fees and attorney fees associated with this account.

Signature of Insured/Guardian

Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Kenneth Sobel for any services furnished to me by this physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature

Date

This information is for use by your physician as part of your confidential medical record.