PATIENT REGISTRATION AND HEALTH UPDATE

PATIENT'S NAME: ______________________ **DATE OF BIRTH:** __________
STREET ADDRESS: ______________________
CITY, STATE, ZIP: ______________________
HOME PHONE: __________ OFFICE: __________ CELL: __________
E-MAIL ADDRESS: ______________________
EMPLOYER: ______________________ OCCUPATION: __________
SOCIAL SECURITY #: __________ DRIVER'S LICENSE #: __________

ALLERGIES TO MEDICATION: ______________________

MARITAL STATUS : (Circle) Single Married Separated Divorced Widow
SPOUSE'S NAME: ______________________ DATE OF BIRTH: __________
HOME PHONE: __________ OFFICE: __________ CELL: __________
SOCIAL SECURITY#: __________ EMPLOYER: __________
IF UNDER 18, PARENT GUARDIAN ______________________

EMERGENCY CONTACT *(Other than spouse)* ______________________
Relation: __________ Phone: ( ) __________
Address ______________________

INSURANCE & BILLING

BILLING NAME *(If other than patient)*: __________ RELATIONSHIP__________
BILLING ADDRESS: ______________________ Phone#: __________

1. Insurance Co: ______________________
   Address __________ Phone#: __________
   Name of Insured:__________ Group#:__________
   Relationship to PT: __________ Social Security __________

2. Insurance Co: ______________________
   Address __________ Phone#: __________
   Name of Insured:__________ Group#:__________
   Relationship to PT: __________ Social Security __________

I attest that the insurance information noted above is the only coverage I have at the current time. Unless noted above, I have no secondary coverage.

Signature______________________ Date__________

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical/medical benefits to Dr. Stanley Stein for services rendered by him in person or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Dr. Stanley Stein to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefits,

MEDICARE/MEDICAID

I certify that the information given by me in applying for payment is correct. I authorize release of all medical records upon request. I request that payment of authorized benefits be made on my behalf.

A photocopy of these assignments shall be valid as the original.

PATIENT (Please Print) ______________________ Date: __________
PARENT/GUARDIAN ______________________
SIGNATURE ______________________

PAYMENT IS REQUIRED AT THE TIME OF SERVICE