Patient Registration Form

Assigned PCP: William Y. Josephson MD.

Patient Information:

Last Name:_____ First Name:_____
MI:_____
Address:_____
City:_____ State:_____ Zip Code:_____
Date of Birth:_____
Social Security Number:_____
Home Phone:_____
Pager/Cell Phone:_____
Driver's License #:_____ State of Driver's License:_____

Patient's Employer Information:

Company Name:_____
Company Address:_____
City:_____ State:_____ Zip Code:_____
Phone:_____ Ext:_____
Occupation:_____

Emergency Contact Information:

Name:_____
Relationship:_____
Address:_____
City:_____ State:_____ Zip Code:_____
Home Phone:_____
Pager/Cell Phone:_____

Insured or Responsible Person:

Primary Insurance:
Insurance Company:_____
Last Name:_____ First Name:_____
MI:_____
Relationship to Patient:_____
Group #:_____
Member ID #:_____

Secondary Insurance:
Insurance Company:_____
Last Name:_____ First Name:_____
MI:_____
Relationship to Patient:_____
Group #:_____

Member ID #:_____

Interpretive Service Needs:

Primary Language:_____
Interpreter Services Required: □ Yes □No

Advance Directives:

Do you have an Advance Directive? □ Yes □No
If yes, please provide us with a copy.
Would you like information regarding Advance Directives? □ Yes □No

Assignment of Benefits: I hereby assign all medical and/ or surgical benefits, to include major medical benefits to which I am entitled, private insurance and any other health plan to the physician/ facility on record. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Authorization of treatment: I hereby authorize the physician of record, and associates to treat the above patient.

Patient's Signature:_____
Date:_____