PATIENT REGISTRATION

DATE

NAME _____ S M W D SEP

DATE OF BIRTH _____ AGE _____

STREET ADDRESS _____

HOME PHONE _____ WORK PHONE _____

CITY, STATE _____ ZIP _____

PRIMARY PHYSICIAN'S NAME & ADDRESS _____

PLACE OF EMPLOYMENT _____

SPOUSE'S NAME _____

SPOUSE'S PLACE OF EMPLOYMENT _____

EMERGENCY CONTACT (OTHER THAN SPOUSE) _____

IF UNDER 18 PARENT/GUARDIAN _____

ADDRESS/ PHONE _____

SOCIAL SECURITY # _____

REFERRED BY _____

INSURANCE & BILLING

BILLILLNG NAME (IF OTHER THAN PATIENT) _____ RELATIONSHIP _____

ATTORNEY: _____

BLUE CROSS/BLUE SHIELD # _____

(circle one): HEALTHMATE 2000 CLASSIC FEDERAL BLUE CHIP PLAN 65 HEALTHMATE COAST TO COAST

UNITED HEALTH PLANS (OCEAN STATE) # _____

MEDICARE / BLUE CHIP MEDICARE (CIRCLE ONE) # _____

MEDICAL ASSISTANCE # _____

PRIVATE INSURANCE _____ INS. ADDRESS _____

POLICY HOLDER/SUBCRIBER NAME _____ D.O.B. _____

WORKMAN'S COMP—INSURANCE COMPANY / MVA: _____

DATE OF INJURY _____ CONTACT PERSON PHONE NUMBER _____

PLACE OF EMPLOYMENT _____

PAYMENT REQUESTED AT TIME OF SERVICE—UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical/medical benefits to Jerrold Rosenberg, MD, 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 Jerrold Rosenberg, MD to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial aid.

I certify that the information given by me in applying for payment is correct. I authorize release of all records on 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 _____ DATE _____

PARENT/GUARDIAN _____ SIGNATURE _____