PATIENT REGISTRATION

Date ___________________

Patient Name ____ Date of Birth ______________

Social Security # ____________________Email Address: __________________________Age___

Home Address ____

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Home #_____________________ Work #____________________ Cell # ____________________

Occupation ________________________ Employer's Name ______________________________

Employer's Address ____

Spouse Name ____________________________Spouse Employer__________________________

Primary Physician's Name ____

Whom May We Thank for Referring You To Our Practice? _______________________________

NOTIFY IN CASE OF EMERGENCY

Name ____ Relationship _____________________

Address ____

Home Number: _______________________ Cell Number: _________________________________

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance with ____ and assign directly to Zena Levine M.D. Medical Corp., Inc. all insurance 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 all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

In addition, I am aware that I will be charged for a missed appointment if giving less than 24 hours notice.

____ ______________________

Patient/Guardian Signature Date

Insured Name & Relationship to Patient ____

Address____

Phone Number _________________________________ Date of Birth ___________________

Update 12/2013