

**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 \_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_ ADDRESS/PHONE \_\_\_\_\_ REFERRED BY \_\_\_\_\_

**INSURANCE & BILLING**

BILLING 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/SUBSCRIBER 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 \_\_\_\_\_