

Patient Registration

(Circle one)

How did you hear about us? Yellow Pages Friends/Family Newspaper Internet Other

Primary or Referring Doctor: _____ **Phone #:** _____
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Patient's Information

Name: _____ S.S.#: _____ D.O.B.: _____ Sex: M or F
Address: _____ Phone#:() _____ Marital Status: _____
_____ Fax#: () _____ Email: _____
Employer: _____ Work #:() _____
Address: _____

Emergency Contact: _____ Phone#: _____
Relationship to Patient: _____
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Responsible Party's Information

Name: _____ DOB: _____ S.S.#: _____
Address: _____ Phone#:() _____ Work#:() _____
_____ Employer: _____
Employer's Address: _____
#####

Primary

Secondary

Insurance: _____ Insurance: _____
Member#: _____ Group#: _____ Member#: _____ Group#: _____
Insured Party: _____ Insured Party: _____
D.O.B.: _____ Employer: _____

Primary Insurance: Circle Patient's Relation to Insured: Self Spouse Child Guardian
Secondary Insurance: Circle Patient's Relation to Insured: Self Spouse Child Guardian
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Please Read the Following and Sign Below

*I hereby request that payment of authorized insurance benefits be made on my behalf to Arnold Kirshenbaum, M.D., c/o Allergy Health Care. In addition, I authorize Dr. Kirshenbaum, as holder of my medical records, to release to my insurance carrier any information necessary to determine benefits payable for these or other related services.

*I understand that I am financially responsible for any non-covered expense and/or balances of covered expenses including, but not limited to, co-pays and deductibles which are due at the time of my visits. I also understand that my account is subject to collections in the event that I do not take care of my responsibilities to the physician after proper notice, and that I am responsible for all collection fees and costs for the collection of my account, including attorneys' fees.

*All bills are due upon receipt. In the event payments are not received within the 30 days, I understand that 1 1/2% per month carrying charge (18% APR) will be added.

*In addition, if I fail to come in for a scheduled appointment without giving 24-hour notice, I am subject to a fee of \$100.00 for a new patient appointment and \$50.00 for a follow-up appointment.

_____(SEAL) Date: _____
(Signature of Patient or Responsible Party)
_____(SEAL) Date: _____
(Witness)