DR. AVSHALOMOV

PATIENT REGISTRATION & HEALTH QUESTIONNAIRE

Primary Care Physician/Pediatrician_____

Address_____Phone( )_____

PATIENT INFORMATION

Patient Name-Last, First_____Sex: M____F____

Address_____

City_____State_____Zip_____

Home Phone( )_____Work Phone( )_____Cell Phone( )_____

Marital Status S__M__D__W__ Social Security #_____Date of Birth ____/____/____Age_____

Spouses Name_____Phone_____

Emergency Contact(Other than Spouse)_____Phone( )_____

Address_____Relation_____

INSURANCE & BILLING INFORMATION

Are you here because of a work-related injury? Yes_____No_____

PAYMENT REQUIRED AT THE TIME OF SERVICE-UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE

Primary Insurance Company_____

Policy #_____Group #_____

Primary Cardholder_____SS#_____

Date of Birth ____/____/_____ Relationship to Patient_____

Secondary Insurance Company_____

Policy #_____Group #_____

Secondary Cardholder_____SS#_____

Date of Birth ____/____/____ Relationship to Patient_____

ASSIGNMENT OF INSURANCE BENEFITS- I hereby authorize direct payment of surgical/medical benefits to DR. GAD AVSHALOMOV for service rendered by him in person or under supervision. I understand that I am financially responsible for any balance not covered by insurance. **AUTHORIZATION TO RELEASE INFORMATION-** I hereby authorize DR.GAD AVSHALOMOV to release any medical or incidental information that may be necessary for either medial care of in processing applications for financial benefits, **ALL INSURANCE**- 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.

I HEREBY CERTIFY THAT ALL THE INFORMATION GIVEN BY ME ABOVE IS CORRECT AND TRUTHFUL.

SIGNATURE OF PATIENT/GUARDIAN_____DATE_____