

PATIENT INFORMATION

Date _____

Patient Name _____, _____, _____
Last First MI

Address _____ Home # (____) _____ - _____

City _____ State _____ ZIP _____ Cell #: (____) _____ - _____

DOB ____/____/____ Age: _____ Sex: M F SS# _____ - _____ - _____

❖ E-Mail _____ @ _____ *Please Provide*

❖ Will ONLY be used for appointment reminders and emergency closings

Occupation: _____ Work # (____) _____ - _____

Employer Name/Address _____

Status Please Check: Single Married Divorced Widowed Domestic Partner

Responsible Party Name and Address _____

Emergency Contact Name _____ #: (____) _____ - _____

Primary Care Physician _____ Referred by: _____

PRIMARY INSURANCE INFORMATION

Insurance ID#: _____ Group #: _____

Insurance Carrier: _____ SS #: _____ - _____ - _____

Policy Holder Name _____, _____, _____
*Last First MI*Policy Holder Birth Date ____/____/____ Sex: M F Relationship to Patient _____ (Self, Spouse, Child)Does your insurance require a referral or pre-authorization? YES NO Co-Pay Amount \$ _____

SECONDARY INSURANCE INFORMATION

Insurance ID #: _____ Group #: _____

Insurance Carrier: _____ SS #: _____ - _____ - _____

Policy Holder Name _____, _____, _____
*Last First MI*Policy Holder Birth Date ____/____/____ Sex: M F

Relationship to Patient _____ (Self, Spouse, Child) Co-Pay Amount \$ _____

I assign and authorize insurance benefits to be paid directly to Dr. Robert M. Rosen. I also understand that I am financially responsible for any balance due. I authorize release of medical information to my insurance company and other medical providers involved in my care. All co-payments, deductibles and non-covered services are due at the time of service. All cosmetic procedures are to be paid at the time of service. It is the responsibility of the patient to understand their individual policy. Appointments must be cancelled 24 hours in advance. All non-cancelled appointments may be subject to charge.

Signature _____ Date: ____/____/____

Please give this form, your insurance cards and driver's license to the receptionist.

Do you give our office permission to discuss your medical information with family members?

YES NO If yes, please provide their name and phone number.

Name: _____ Relationship _____
Phone #: Home (____) _____ - _____ Cell: (____) _____ - _____

May we leave personal medical information on your answering machine at home? YES NO

May we e-mail personal medical information to you? YES NO

Signature: _____

Date: ____/____/____

FOR MEDICARE PATIENTS: This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payer if they require it for the proper consideration of a claim. Please read and sign the following statement:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services, or its intermediaries or carrier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

_____/____/____
Signature as it appears on Medicare Card **Date**

If you have a supplemental policy and it is a MEDIGAP policy to which your Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file:

I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services

_____/____/____
Signature as it appears on Medigap Card **Date**