

Patient Registration

Patient Information

Patient Name _____ Sex _____ Date of Birth _____

Social Security Number _____

Address _____

City _____ State _____ Zip _____

Email _____ Home Phone _____ Cell/Work _____

Employer _____ Occupation _____

Employer Address _____

How did you hear about us? _____

Doctors Seen in the Past _____

Emergency Contact Information

Emergency Contact _____ Relationship _____

Home Phone _____ Cell/Work _____

Full Address _____

Medical Insurance Information

Name of Insured _____ Relationship to Patient _____

Insurance Name _____ Medicare Number _____

Insurance ID _____ Group/Policy# _____

Insurance Address _____ Phone _____

Insurance Benefits

I hereby assign all medical and/or surgical insurance benefits to which I am entitled, including major medical, private insurance, health plans, and Medicare to Irene Teper, M.D. I understand that if Dr. Teper is not a participating member of my insurance coverage, I am responsible for paying my bills and for submitting claims to my insurance company. I hereby authorize Dr. Teper to release medical information to any physician, insurance company, hospital, or health plan. I have completed this form fully and completely and certify that I am the patient or the patient's agent authorized to furnish the information requested and to sign this form.

Patient Signature _____ Date _____