DIMITRY RABKIN, M.D., P.C.

PATIENT REGISTRATION

PATIENT INFORMATION:

PLEASE PRINT

TODAY'S DATE: _____

PATIENT NAME: _____ _____ _____
LAST MIDDLE FIRST

PARENT IF PATIENT IS A MINOR: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: HOME: (_____) _____ WORK: (_____) _____ CELL: (_____) _____

E-MAIL _____

DATE OF BIRTH: _____ AGE: _____ SS #: _____

SEX: M _____ F _____ MARRIED ( ) SINGLE ( ) DIVORCED ( ) WIDOWED ( )

EMERGENCY CONTACT NAME AND PHONE: _____

ARE YOU A FULL-TIME STUDENT ( ) PART-TIME STUDENT ( ) EMPLOYED ( ) RETIRED ( )

WERE YOU REFERRED BY YOUR DOCTOR? YES _____ NO _____

NAME, PHONE NUMBER AND ADDRESS OF YOUR DOCTOR_____

_____

HOW DID YOU HEAR ABOUT OUR OFFICE?_____

FINANCIAL INFORMATION: PERSON RESPONSIBLE FOR FEES:

PRIMARY INSURANCE:

SUBSCRIBER'S NAME : _____

RELATIONSHIP TO PATIENT: SELF ( ) SPOUSE ( ) PARENT ( ) OTHER ( )

SUBSCRIBER'S DATE OF BIRTH: _____ SUBSCRIBER'S SS#: _____

INSURANCE COMPANY: _____ INSURANCE ID#: _____

GROUP #: _____

SECONDARY INSURANCE:

SUBSCRIBER'S NAME : _____

RELATIONSHIP TO PATIENT: SELF ( ) SPOUSE ( ) PARENT ( ) OTHER ( )

SUBSCRIBER'S DATE OF BIRTH: _____ SUBSCRIBER'S SS#: _____

INSURANCE COMPANY: _____ INSURANCE ID# _____

GROUP #: _____

FINANCIAL DISCLOSURE/SIGNATURE RELEASE:

I AUTHORIZE MY INSURANCE COMPANY TO PAY DIRECTLY TO DIMITRY RABKIN, M.D., P.C. ALL BENEFITS DUE. THIS POLICY IS IN FULL FORCE & EFFECT AT THE TIME OF TREATMENT. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL APPLICABLE COINSURANCES, DEDUCTIBLES, COPAYS AND ANY BALANCES REMAINING AFTER PAYMENT FOR UNCOVERED SERVICES, AND THAT, SHOULD IT BECOME NECESSARY, ANY AND ALL REASONABLE COLLECTION/ATTORNEY FEES WILL BE ADDED TO THE PATIENT'S BILL. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL.

AUTHORIZATION TO RELEASE INFORMATION:

I HEREBY AUTHORIZE DIMITRY RABKIN, M.D., P.C. TO FURNISH INFORMATION TO MY INSURANCE CARRIERS AND TO OTHER PHYSICIANS WHO MAY BECOME INVOLVED IN MY CARE, CONCERNING ILLNESS AND TREATMENTS RECEIVED BY ME. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL.

LEGAL SIGNATURE: _____ DATE: _____