

Jeffrey E. Goldberg, M.D., P.C.
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DATE _____

PATIENT REGISTRATION FORM
PLEASE COMPLETE THIS FORM IN ITS ENTIRETY

PATIENT'S LEGAL NAME _____ DOB _____ SEX _____

HOME PHONE _____ CELL PHONE _____ EMAIL _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PARENT'S NAME (if pediatric patient) _____

PRIMARY CARE PHYSICIAN _____ PHARMACY & PHONE _____

REFERRED BY: PRIMARY CARE PHYSICIAN FRIEND (name) _____

PRIMARY INSURANCE/ RESPONSIBLE PARTY (information regarding **adult** responsible for payment)

CARRIER _____ ID# _____ GROUP # _____

INSURED (ADULT) NAME _____ DOB _____

INSURED SS# _____ RELATION TO PATIENT _____

ADDRESS (IF DIFFERENT) _____

EMPLOYER _____ WORK PHONE _____

SECONDARY INSURANCE

CARRIER _____ ID# _____ GROUP # _____

INSURED NAME _____ DOB _____

INSURED SS# _____ RELATION TO PATIENT _____

ADDRESS (IF DIFFERENT) _____

EMPLOYER _____ WORK PHONE _____

EMERGENCY INFORMATION

CONTACT NAME _____ RELATION TO PATIENT _____

PHONE NUMBERS _____

ADDRESS (IF KNOWN) _____

CONSENT TO RELEASE MEDICAL INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby consent to the release of medical information to any insurance carrier, other treating physician office, or other party that I may direct by the staff of Jeffrey E. Goldberg, M.D., P.C. I further direct that all payments from insurance carriers be assigned and sent to Jeffrey E. Goldberg, M.D., P.C. for services rendered. Any amount not paid by insurance must be paid by the patient or Responsible Party.

CONSENT TO MEDICAL TREATMENT

I hereby consent to the medical treatment for the above mentioned patient by the medical staff of Jeffrey E. Goldberg, M.D., P.C. I further state that I am duly authorized under law to consent to the medical treatment obtained.

AUTHORIZED SIGNATURE _____ DATE _____

PRINT NAME _____