

PATIENT REGISTRATION SHEET

TODAY'S DATE _____ DATE OF BIRTH _____

PATIENT'S NAME _____

Please choose a preferred sur-title: Mr. Mrs. Ms. Miss. Other _____

SOCIAL SECURITY NO. _____ AGE _____ SEX: M F

PHYSICAL ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____

EMPLOYED BY _____ OCCUPATION _____

EMAIL ADDRESS _____

EMERGENCY CONTACT (Other than spouse) _____ PHONE _____

Has any immediate family member been seen by Dr. Bernitsky? Y N

For your privacy and protection of patient information, please answer the following:

MAY WE LEAVE MESSAGE ON YOUR HOME ANSWERING MACHINE? Y N

MAY WE LEAVE MESSAGES WITH YOUR SPOUSE? Y N

MAY WE SPEAK TO YOUR SPOUSE ON YOUR BEHALF? Y N

PRIMARY CARE PHYSICIAN _____ PHONE _____

REFERRING PHYSICIAN _____ PHONE _____

BILLING AND INSURANCE INFORMATION

PRIMARY INSURANCE _____ POLICY HOLDER NAME _____

POLICY NUMBER _____ GROUP NUMBER _____

SECONDARY INSURANCE _____ POLICY HOLDER NAME _____

POLICY NUMBER _____ GROUP NUMBER _____

Insurance card must be photocopied. Please bring to reception desk when returning this form.

RESPONSIBLE PARTY IF DIFFERENT FROM THE PATIENT

NAME _____ PHONE _____

ADDRESS _____

SOCIAL SECURITY NO. _____ DATE OF BIRTH _____

Assignment of benefits/authorization to release medical information/responsible party statement

I, the undersigned, authorize payment of benefits as determined by the Company, directly to David A. Bernitsky, M.D. I authorize David A. Bernitsky, M.D. to release any information requested, including medical information, to any insurance company, employer, third party payor, or administrator for purposes of processing my medical claims. As the responsible party, I agree that I am responsible for payment of non-covered services, co-payments, coinsurance and/or deductibles in accordance with the terms and conditions of my health insurance policy.

PATIENT SIGNATURE/RESPONSIBLE PARTY _____ DATE _____

D A V I D A . B E R N I T S K Y M . D .