

JAMES R. BERENSON, M.D., INC.

REGISTRATION FORM

(Please Print)

Today's Date ____/____/____

Physician: _____

PATIENT INFORMATION

Patient's Last Name	First	Middle	<input type="checkbox"/> Mr.	<input type="checkbox"/> Miss	Marital Status (Circle One) Single / Mar / Div / Sep / Wid
			<input type="checkbox"/> Mrs.	<input type="checkbox"/> Ms.	

Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	Social Security	Birth Date / /	Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F
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Street Address	Home Phone No. ()	Cell Phone No. ()
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P.O. Box	City	State	ZIP Code
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Occupation	Employer	Employer Phone No. ()
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Chose Clinic Because/Referred to Clinic by (Please check one box) Dr. _____ Insurance Plan Hospital

Family Friend Close to Home/Work Yellow Pages Other _____

Spouse/ or Significant Other Name _____

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Person Responsible for Bill	Birth Date / /	Address (if different)	Home Phone No. ()
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Is this person a patient here?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
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Occupation	Employer	Employer Address	Employer Phone No. ()
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Is this patient covered by insurance? Yes No

Please indicate primary insurance Medicare Medi-Cal Blue-Cross Blue Shield Aetna

Cigna PacifiCare SAG Motion Picture Other _____

(Please provide referral/authorization form if applicable)

Subscriber's Name	Subscriber's S.S. #	Birth Date / /	Group #	Policy #	Co-Payment \$
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Patient's Relationship to Subscriber Self Spouse Child Other _____

Name of Secondary Insurance (if applicable)	Subscriber's Name	Group #	Policy #
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Patient's Relationship to Subscriber Self Spouse Child Other _____

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Patient	Home Phone No. ()	Work Phone No. ()
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The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I hereby assign to JAMES R. BERENSON, M.D., INC. any insurance or other third-party benefits available for health care services provided to me. I understand that JAMES R. BERENSON, M.D., INC. has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to JAMES R. BERENSON, M.D., INC., I agree to forward to JAMES R. BERENSON, M.D., INC. all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt. I also authorize James R. Berenson, M.D., Inc. to release any information required to process my claims.

X _____
PATIENT/GUARDIAN SIGNATURE
DATE