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

REGISTRATION FORM

(Please Print)

Today's Date ____/____/____ Physician: _____

PATIENT INFORMATION

Patient's Last Name	First	Middle	❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.	Marital Status (Circle One) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Social Security	Birth Date / /	Age	Sex ❑ M ❑ F

Street Address	Email Address	Home Phone No. ( )	Cell Phone No. ( )

P.O. Box City State ZIP Code

Occupation	Employer	Employer Phone No. ( )

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. ( )
Is this person a patient here?	❑ Yes ❑ No		

Occupation	Employer	Employer Address	Employer Phone No. ( )

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 $

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other _____

Name of Secondary Insurance (if applicable)	Subscriber's Name	Group #	Policy #

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. ( )

The above information is true to the best of my knowledge. I authorize mu 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, MD., 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

Revised 04/2004:vap