

NEW PATIENT REGISTRATION

LAST NAME: _____ SEX: M _____ F _____
FIRST NAME: _____ MI: _____ BIRTHDATE: _____
ADDRESS: _____ HOME#: _____

WORK#: _____
CITY: _____ EXT. _____
STATE: _____ ZIP: _____ CELL #: _____
E-MAIL: _____ SOC. SEC. #: _____
ALLERGIES: _____

MARITAL STATUS: MARRIED _____ SINGLE _____ OTHER _____

PHYSICIAN: DR. FINE DR. BALDANZA DR. SON DR. JEURLING DR. JOHNSTON

REFERRING PHYSICIAN: _____ PHONE: _____
FAMILY PHYSICIAN: _____ PHONE: _____
EMERGENCY CONTACT: _____ RELATION: _____ PHONE: _____

INSURANCE INFORMATION

PRIMARY INSURER: _____

POLICY HOLDER: _____ RELATIONSHIP: SPOUSE CHILD SELF OTHER
POLICY HOLDER EMPLOYER: _____ HOLDER'S BIRTHDATE: _____
PREFIX/POLICY#: _____ GROUP#: _____ EFF. DATE: _____

SECONDARY INSURER: _____

POLICY HOLDER: _____ RELATIONSHIP: SPOUSE CHILD SELF OTHER
POLICY HOLDER EMPLOYER: _____ HOLDER'S BIRTHDATE: _____
PREFIX/POLICY#: _____ GROUP#: _____ EFF. DATE: _____

PATIENT'S AUTHORIZATION

I AUTHORIZE FALLS MEDICAL SPECIALISTS TO APPLY FOR BENEFITS ON MY BEHALF FOR SERVICES RENDERED BY FALLS MEDICAL SPECIALISTS. I REQUEST PAYMENT FROM MY INSURANCE COMPANY BE MADE DIRECTLY TO FALLS MEDICAL SPECIALISTS. I CERTIFY THAT THE INFORMATION I HAVE REPORTED WITH REGARD TO MY INSURANCE COVERAGE IS CORRECT AND FURTHER AUTHORIZE THE RELEASE OF ANY NECESSARY INFORMATION, INCLUDING MEDICAL INFORMATION FOR THIS OR ANY RELATED CLAIMS. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL. THIS AUTHORIZATION MAY BE REVOKED BY ME AT ANY TIME IN WRITING. I UNDERSTAND THAT NOTHING HEREIN RELIEVES ME OF THE PRIMARY RESPONSIBILTY AND OBLIGATION TO PAY FOR MEDICAL SERVICES PROVIDED, WHEN A STATEMENT IS RENDERED.

SIGNATURE OF SUBSCRIBER OR BENEFICIARY _____
DATE