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 (CIRCLE ONE): **DR. FINE** **DR. MCGINNIS** **DR. BALDANZA** **DR. PARSA**

REFERRING PHYSICIAN: _____ PHONE: _____

FAMILY PHYSICIAN: _____PHONE: _____

EMERGENCY CONTACT: _____ RELATION:_____ PHONE: _____

INSURANCE INFORMATION

(Please complete ONLY if you are NOT the primary cardholder)

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