Patient Information

SSN#_____ DOB:_____ Age:_____

Name (Last, First)_____ M.I._____ Maiden or Nickname_____

Address_____Apt:_____

City_____ State _____ Zip _____

Home Phone (_____) _____-_____ Work Phone (_____) _____-_____ ext._____

Email _____ Marital Status _____

Employer Information

Employer _____ Occupation_____

Address _____ FT/PT Student?_____

City_____ State _____ Zip _____

Insurance Information: Primary/ Secondary/ Other

*****Please Provide Your Insurance Card To The Receptionist*****

Are You Using Health Insurance? Yes ☐/☐ No (Circle One)

Primary Ins. Company:_____ Policy Holder: ☐Self ☐Parent ☐Spouse ☐Other (Explain)_____

Secondary Ins. Company:_____ Policy Holder: ☐Self ☐Parent ☐Spouse ☐Other (Explain)_____

Spouse/ Parent's Information (if covered by Spouse/Parent Insurance)

Name _____ Phone (_____) _____-_____ Relation_____

SSN#_____ DOB:_____ Age:_____

Employer _____ Occupation_____

Address _____

City_____ State _____ Zip _____

Emergency Information

Please list the nearest living relative/friend other than your spouse/ parent

In case of emergency, we may contact:

_____

(_____) ___ -_____ _____

Phone No. Relationship

Other

Primary Care Physician's Name:

_____

For any exchange of records or information beteween Dr. Reiner and your Primary Care Physician, please fill out a Consent of Release of Information form.

How Did You Find Out About Us?

☐ From a current Patient?
Name: _____

☐ Referred by Physician?
Name: _____

☐ Advertising ☐ Yellow Pages
☐ Yelp ☐ Insurance Directory

Authorization for Payment

I authorize the release of medical information necessary to process the claims for medical benefits. I authorize and assign any payment of medical benefits to_____, its successors and assigns, or any individual it may designate for services provided.
I further agree to pay all costs of collection, including attorney's fees, associated with collection of any amount due to services rendered and performed. I will pay interest at the prevailing annual rate for all amounts 30 days past due. I understand that I am financially responsible to _____, its successors and assigns and any individual it may designate for any balance not covered by insurance.

_____

Signature of Patient/ Guardian Date

Authorization for Medicare

I request that payment of Authorized Medicare benefits be made either to me or on my behalf to _____ for services furnished to me by the provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

_____

Patient Signature Date