Alexander Shifrin Medical P.C. – Patient Registration

Thank you for choosing our practice and welcome!

PATIENT INFORMATION

Last Name	First Name	SS#	DOB

Street Address	Apt. #	City	State	Zip Code

Occupation	Employer's Name	Employer's Address

Marital Status S M D W	Spouse's Name (Last, First)	Spouse's DOB

Ethnicity/Race ☐White ☐Black/African American ☐Asian ☐Hispanic/ Latino ☐Other /Specify: ☐Declined to report

How did you find us? ☐Insurance Directory ☐Website ☐Internet ☐Current Patient/Name: ☐Physician/ Name: ☐Other/Specify:

CONTACT

Cell Phone	Home Phone	Work Phone	Email

Emergency Contact Name (Last, First)	Relationship	Phone

INSURANCE

Primary Insurance Carrier	ID Number	Insured's Name (Last, First)	Insured's DOB
Secondary Insurance Carrier	ID Number	Insured's Name (Last, First)	Insured's DOB

PRIMARY CARE PHYSICIAN

Name (Last, First)	Address	Phone

PHARMACY

Name	Address	Phone

CREDIT CARD AUTHORIZATION: Our office offers the convenience of having a credit card on file. Charges to your card will be made only with you authorization. By filling the information below, you consent for our office to bill the credit card on file.

Credit Card: Amex Visa Master	Card #	Security #	Expiration Date

Credit Card's Billing Address	Apt. #	City	State	Zip Code

Credit Card Holder's Name (Last, First)	Credit Card Holder's Signature

REQUEST FOR PAYMENT AND ASSIGNMENT OF BENEFITS: I hereby assign my insurance benefits to be paid directly to the physician in this office. I am financially responsible for non-covered services. I hereby authorize the release of medical information related to the services received in this office. I am responsible for informing this office of any change in my health insurance plans.

Signature of the Patient/Guardian ______________________ Date ______________

FOR MEDICARE RECIPIENTS ONLY: I request that payment of Authorized Medicare benefits be made either to me or on my behalf to Alexander Shifrin Medical P.C. 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 to related services.

Signature of the Patient/Guardian ______________________ Date ______________

I CERTIFY THAT THE INFORMATION ON THIS FORM IS CORRECT AND CURRENT TO THE BEST OF MY KNOWLEDGE.

Signature of the Patient/Guardian ______________________ Date ______________