REGISTRATION FORM

DATE: _____ Mark P. Stesin, M.D., PA

PATIENT _____
(last) (first) (initial)

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE _____

EMAIL: _____ **PHONE** ( ) _____

SEX: M F SINGLE MARRIED WIDOWED SEPARATED DIVORCED

PATIENT'S SOCIAL SECURITY # _____ AGE _____ **BIRTHDATE** _____ / _____ / _____

SPOUSE'S SOCIAL SECURITY # _____ AGE _____ **BIRTHDATE** _____ / _____ / _____

PATIENT'S EMPLOYER _____

BUSINESS ADDRESS _____

BUSINESS PHONE _____ OCCUPATION _____

SPOUSE'S / RESP PARTY EMPLOYER _____

BUSINESS ADDRESS _____

BUSINESS PHONE _____ OCCUPATION _____

WHO IS RESPONSIBLE FOR THIS ACCOUNT? _____

RELATIONSHIP TO PATIENT? _____

DO YOU HAVE HEALTH INSURANCE? YES NO

DO YOU HAVE A COPAY? YES NO AMOUNT _____

PRIMARY INSURANCE _____ **SECONDARY INS** _____

INSURED NAME _____ **INSURED NAME** _____

ID # _____ **ID #** _____

GROUP # _____ **GROUP #** _____

OTHER INSURANCE INFORMATION _____

EMERGENCY CONTACT (NOT LIVING WITH YOU) _____

RELATIONSHIP _____ PHONE # _____

WHO IS YOUR FAMILY/REFERRING PHYSICIAN? _____

ASSIGNMENT OF BENEFITS

I hereby authorize the release of information relating to all claims for benefits submitted on behalf of myself and/or dependents. My signature on this form authorizes my physician to submit claims for benefits, for services rendered, without obtaining my signature on each claim submitted. I will be bound by this signature as if I had signed each claim individually.

I, _____, hereby authorize _____
(insured) (insurance company)

to pay and hereby assign directly to **MARK P. STESIN, M.D., P.A.** all benefits, if any, payable to me for services rendered. I understand that I am financially responsible for all charges incurred and that any insurance payments recieved by **MARK P. STESIN, M.D., P.A.** will be credited to my account, in accordance with the above said agreement.

_____ _____
SUBSCRIBER/OR AUTHORIZED SIGNATURE **DATE**