Cohen & Sheinker MD PA

NEW PATIENT REGISTRATION FORM

PATIENT NAME(S) [LAST, FIRST, MIDDLE INITIAL]: **DATE(S) OF BIRTH:** **GENDER:**

1. _____ _____ **M / F**

2. _____ _____ **M / F**

3. _____ _____ **M / F**

4. _____ _____ **M / F**

MOTHER'S NAME [LAST, FIRST]: _____ **DOB:** _____

ADDRESS: _____ **APT:** _____

CITY: _____ **STATE:** _____ **ZIP:** _____

PRIMARY PHONE #: _____ **(HOME/CELL)** **ALT PHONE #:** _____ **(HOME/CELL)**

EMAIL: _____ **SSN:** _____

EMPLOYER: _____ **OCCUPATION:** _____

FATHER'S NAME [LAST, FIRST]: _____ **DOB:** _____

ADDRESS: _____ APT: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

PRIMARY PHONE #: _____ **(HOME/CELL)** **ALT PHONE #:** _____ **(HOME/CELL)**

EMAIL: _____ SSN: _____

EMPLOYER: _____ **OCCUPATION:** _____

INSURANCE CO: _____ **SUBSCRIBER NAME & RELATION TO PATIENT:** _____

MEMBER ID#: _____ **GROUP #:** _____

PATIENT'S EMERGENCY CONTACT & RELATION TO PATIENT: _____

REFERRED TO OUR OFFICE BY: _____ **OB NAME:** _____

As Parent or Legal Guardian, I give permission to Cohen & Sheinker MD PA to treat the patient(s) listed above. I agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I agree to pay for all services rendered in accordance with the financial policy of this practice. I am responsible for knowing the specifics of his/her insurance plan and its procedures. I am responsible for checking my benefits with my insurance carrier prior to visiting a specialist, obtaining diagnostics tests, labs or any other outside procedure. I will notify this office of any changes in my medical insurance or any other personal information that I have provided on the demographics form. If a balance remains on my account longer than 60 days, I hereby authorize Cohen & Sheinker, MDPA to charge the full amount to the credit card I have left on file.

Please sign below signifying that you have read and understand the above statement and that this office has permission to submit insurance claims on your behalf and has permission to release any information, including medical records, to the above insurance carrier or its affiliated agent. This office is not responsible for any dissemination or disclosure of your confidential medical information once we provide such information, at your request, to your health insurer, employer or agent.

SIGNATURE: _____ **DATE:** _____

PRINT NAME OF SIGNING PARENT OR LEGAL GUARDIAN: _____