

## PATIENT REGISTRATION

Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_

Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Social Security #: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Cell Phone: (\_\_\_\_) \_\_\_\_\_

Pharmacy Phone (\_\_\_\_) \_\_\_\_\_ Fax # (\_\_\_\_) \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Work Phone: (\_\_\_\_) \_\_\_\_\_ Social Security # \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
Referred By \_\_\_\_\_

Method of Payment: Insurance \_\_\_\_\_ Cash \_\_\_\_\_ Check \_\_\_\_\_ MasterCard/VISA \_\_\_\_\_

Primary Language Spoken: English \_\_\_\_\_ Spanish \_\_\_\_\_ Other \_\_\_\_\_

## INSURANCE INFORMATION

Company: \_\_\_\_\_ ID#: \_\_\_\_\_

Address: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Group#: \_\_\_\_\_

## ASSIGNMENT OF BENEFITS

I hereby authorize direct payment of surgical/medical benefits to Mark S. Denker, M.D., P.A. for services rendered by him in person or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance. I certify that the information given by me in applying for payment is correct. I authorize release of all records on request. I request that payment of authorized benefits be made on my behalf.

Signature: \_\_\_\_\_ Date \_\_\_\_\_