Michael P. Bernstein, M.D.

PATIENT REGISTRATION page 1

Patient Name ________________________ SS# ____________
Responsible Party ________________________
Patients Date of Birth ____________ Age ______ Marital Status S M W SEP D
Street Address ________________________
City ____________ State ____________ Zip ____________
Tel # home ____________ Office ____________
Referred by ________________________
Spouses Name ________________________
Spouses employer/address ________________________
Emergency Contact ____________ Tel. # ____________ Relationship ____________

Patient Employer Information

Employer Name ________________________ Tel. # ____________
Employer Street Address ____________ City/State ____________ Zip ____________
Patient's Occupation ________________________

Insured Person (If not patient)

Name ________________________ Tel. # ____________
Street Address ____________ City/State ____________ Zip ____________
Relationship to patient ____________ Employer Name ____________

Insurance

Primary Insurance ____________ Subscriber ____________
Address/ Phone ____________ Policy # ____________
Secondary Insurance ____________ Subscriber ____________
Address/Phone ____________ Policy # ____________

Authorization to Release Information and Assignment of Benefit

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in the place of the original.

Date ____________ Signature ________________________

I hearby authorize Dr.________________________to apply for benefits on my behalf for covered services rendered by him/her, or by his/her order. I request that payment from my insurance company be made directly to Dr. Michael P. Bernstein.

I certify that the information I have reported with regard to my insurance coverage is correct.

I permit a copy of this authorization to be used in place of the original. This authorization my be revoked by either me or my insurance company at any time in writing.

Date ____________ Signature ________________________

Patient, Parent or Guardian