

Gary J. Stadtmauer M.D. Patient Registration Form

Name _____ D.O.B. _____ Sex assigned at birth: M F
(last) (first)

Address _____

Home phone _____ Cell phone _____ and please include your phone carrier for e-texting: Verizon T-Mobile AT&T Google-Fi Other: _____

Email _____ Name of Employer _____

Social Security # _____ Marital status: Single Married/Partnered Widowed

Referring Doctor _____ Address _____ Phone _____

Primary Doctor _____ Address _____ Phone _____

Insurance company name _____ ID number _____
(as appears on your card, including the prefix)

Name and birthday of insured _____ Relationship to insured _____

If you have secondary/supplemental health insurance please provide name/ID/insured information below:

Emergency Contact _____ Phone _____ Relationship _____

Preferred Pharmacy & Phone Number _____

Assignment of Benefits

I authorize payment of medical benefits to the named provider for professional services

Signed _____
Date _____

Release of information

I authorize the release of any medical information necessary to process this claim.

Signed _____
Date _____

Financial Responsibility

I acknowledge that it is my responsibility to understand my insurance plan. I am responsible for all copays, coinsurance & deductibles payable as well as obtaining up to date referrals to the named provider for professional services AND that without this referral, my insurance will not pay for the services rendered, in which case I will be responsible for the practices standard fees which may exceed my contracted insurance rate. I acknowledge that failure to pay for said services to the doctor within 3 months may lead to collections by a 3rd party (collections agency) with additional collections charges.

Signature _____ Date _____

Relationship (if not self) _____

Name (if not self) _____

Health Information Privacy Notice

The HIPAA (Health Insurance Portability and Accountability Act) notice was made available to me in the doctor's office or online.

Signature _____ Date _____

Relationship (if not self) _____

Name (if not self) _____

Date _____