

Gary J. Stadtmauer M.D. Patient Registration Form

Name(last,first)_____ D.O.B_____ Birth Gender M/F

Address_____

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

Email _____ Name of Employer_____

Social Security #_____ Marital Status_____

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 _____

Financial Responsibility

I acknowledge that it is my responsibility to understand my insurance plan. I am responsible for all copays, coinsurance & deductibles payable AND obtaining up to date referrals for professional services AND understand 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) _____

CC # _____ (Visa/MC)

Exp: _____ Sec Code: _____

Permission to charge patient responsibility. Initials: _____

Assignment of Benefits

I authorize payment of medical benefits to 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 _____

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) _____