

Richard Podolny MD LLC  
**PATIENT REGISTRATION**

**Today's Date:** \_\_\_\_\_

**Referring Doctor or Patient:** \_\_\_\_\_

***PATIENT INFORMATION:***

Patient Name: \_\_\_\_\_

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

Street Address      Apartment      City      State      Zip Code

Home Telephone Number: \_\_\_\_\_ Sex:  Female  Male

Cellular Telephone Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Marital Status:  Single  Married  Other

Name of Spouse/Partner/Significant other: \_\_\_\_\_

Minors, name of parents: \_\_\_\_\_

Patient Social Security Number: \_\_\_\_\_

Patient Email address: \_\_\_\_\_

***EMPLOYMENT INFORMATION:***

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

Work Address: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

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

Spouse Work Address: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

***If you are a minor:***

Employer of Father/Guardian: \_\_\_\_\_ Occupation: \_\_\_\_\_

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

Employer Telephone Number: \_\_\_\_\_

Social Security number of Father/Guardian: \_\_\_\_\_

Employer of Mother/Guardian: \_\_\_\_\_ Occupation: \_\_\_\_\_

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

Employer Telephone Number: \_\_\_\_\_

Social Security number of Mother/Guardian: \_\_\_\_\_

***EMERGENCY INFORMATION:***

Person to notify in the event of an emergency:

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Emergency Phone: \_\_\_\_\_

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

## INSURANCE / BILLING INFORMATION

*To accurately file your insurance claims on your behalf the following information is needed, in addition to a copy of your card.*

**Primary Insurance Carrier:** \_\_\_\_\_

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

Policy Number: \_\_\_\_\_ Medical Code: \_\_\_\_\_

Vision Code: \_\_\_\_\_ Group Number \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Subscriber's Date of Birth: \_\_\_\_\_

**Secondary Insurance Carrier:** \_\_\_\_\_

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

Policy Number: \_\_\_\_\_ Medical Code: \_\_\_\_\_

Vision Code: \_\_\_\_\_ Group Number \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Subscriber's Date of Birth: \_\_\_\_\_

**Other Insurance Carrier:** \_\_\_\_\_

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

Policy Number: \_\_\_\_\_ Medical Code: \_\_\_\_\_

Vision Code: \_\_\_\_\_ Group Number \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Subscriber's Date of Birth: \_\_\_\_\_

**Assignment of insurance benefits:** I hereby assign to the doctor all money to which I am entitled for expenses relative to the services performed from time to time but not to exceed my indebtedness to said doctor. It is understood that any money received from the above named insurance company over and above my indebtedness will be refunded to me when my bill is paid in full. I understand I am financially responsible to the doctor for his charges.

**X** \_\_\_\_\_

\_\_\_\_\_

Patient / Responsible Party's Signature

Date (Required)