8.2-MTBC-F-09

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*CONFIDENTIAL*

# Elzbieta J. Baranowska Daca, M.D

***REGISTRATION INFORMATION***

***PLEASE PRINT***

◯ New Patient

◯ Existing Patient

**Existing Patient:** Revise all information that has changed since your last visit

**DATE** ____/____/_____ **EMAIL ADDRESS** _____ **HOME PHONE:** (_____) _____-_____

**CELL PHONE:** (_____) _____-_____

**PATIENT'S NAME:** _____ , _____ _____

*LAST* *FIRST* *MI*

**STREET ADDRESS:** _____

**CITY:** _____ **STATE:** _____ **ZIP:** _____

**SSN:** _____ - _____ - _____ **GENDER:** ◯ *M* ◯ *F* **BIRTH-DATE:** _____/_____/_____ ◯ *SINGLE* ◯ *MARRIED* ◯ *DIVORCED* ◯ *SEPARATED* ◯ *WIDOWED*

**Patient Employed By :** _____

**Business Address:** _____

**Occupation:** _____ **Business Phone:** (_____) _____-_____

**Name of Spouse/Responsible Party (If Patient is minor):** _____ , _____ _____

*LAST* *FIRST* *MI*

**Spouse/Responsible Party Employed by:** _____

**Business Address:** _____

**Occupation:** _____ **Business Phone:** (_____) _____-_____

**RESPONSIBLE PARTY/SPOUSE SSN :** _____ - _____ - _____

**DO YOU HAVE MEDICAL INSURANCE ?** ◯ NO ◯ YES **If Yes:**

**NAME OF PRI. INS. :** _____ **ID #:** _____ **GRP #:** _____

***SUBSCRIBER'S NAME:** _____ ***BIRTH DATE:** _____/_____/_____

**ADDRESS OF PRI. INS. :** _____

**NAME OF SEC. INS. :** _____ **ID #:** _____ ***GRP #:*** _____

***SUBSCRIBER'S NAME:** _____ ***BIRTH DATE:** _____/_____/_____

**ADDRESS OF SEC. INS. :** _____

***Required by HIPAA**

◯ Pay my balance at the time of service ◯ Pay my balance upon receipt of first statement ◯ Make payment arrangement prior to rendering of services.

In case of emergency, who should be notified? _____ Relationship _____

Person authorized to receive PHI _____ Relationship _____

***PHONE:*** *(_____) _____-_____*

**ASSIGNMENT OF INSURANCE BENEFITS**

I, the undersigned, hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I, _____ hereby authorize _____

**(NAME OF INSURED)** **(NAME OF INSURANCE COMPANY)**

to pay and hereby assign directly to _____ all benefits, if any, otherwise payable to

**(PROVIDER'S NAME)**

me for his/her services as described on the attached forms. I understand I am financially responsible for charges incurred. I further acknowledge that any insurance benefits, when received by and paid to _____

**(PROVIDER'S NAME)**

will be credited to my account, in accordance with the above said assignment.

_____ _____

**(AUTHORIZED SIGNATURE OF SUBSCRIBER)** **(DATE)**