

# WELCOME TO OUR OFFICE

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

If Child, Parent's Name: \_\_\_\_\_

Street Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Social Security No.: \_\_\_\_\_ Male/Female Single: \_\_\_\_\_ Married: \_\_\_\_\_ Div: \_\_\_\_\_ Widow: \_\_\_\_\_

Email: \_\_\_\_\_

Patient (Parent) Employer: \_\_\_\_\_ Position: \_\_\_\_\_

Employer's Address: \_\_\_\_\_ Phone No.: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Spouse's Social Security No.: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_

Spouse's Employer's Address: \_\_\_\_\_ Phone No.: \_\_\_\_\_

Patient's Primary Care Physician: \_\_\_\_\_ Address: \_\_\_\_\_

Referred By: \_\_\_\_\_ How did you learn about us? \_\_\_\_\_

Purpose of this Appointment: \_\_\_\_\_

Emergency Contact Person at Different Address: \_\_\_\_\_ Phone No.: \_\_\_\_\_

Were you seen by one of our Doctors in the Hospital? \_\_\_\_\_ ACMC/City: \_\_\_\_\_ Mainland: \_\_\_\_\_ Shore: \_\_\_\_\_ Other: \_\_\_\_\_

Are you ALLERGIC to any Medications? \_\_\_\_\_

## INSURANCE INFORMATION

Primary Insurance: \_\_\_\_\_

ID No.: \_\_\_\_\_ Group No.: \_\_\_\_\_

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

Patient's Relationship to Subscriber: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_

ID No.: \_\_\_\_\_ Group No.: \_\_\_\_\_

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

Patient's Relationship to Subscriber: \_\_\_\_\_

Is this an Auto Accident Case? \_\_\_\_\_ Date of Accident: \_\_\_\_\_

Motor Vehicle Carrier: \_\_\_\_\_

Adjuster's Name: \_\_\_\_\_ Claim No.: \_\_\_\_\_

Motor Vehicle Carrier Address: \_\_\_\_\_ Phone No.: \_\_\_\_\_

Do you have an Attorney handling this case? \_\_\_\_\_ Attorney's Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone No.: \_\_\_\_\_

Is this a Worker's Comp Case? \_\_\_\_\_ Date of Injury: \_\_\_\_\_

Claim No.: \_\_\_\_\_ Contact Person: \_\_\_\_\_ Phone No.: \_\_\_\_\_

## AUTHORIZATION/RESPONSIBILITY AGREEMENT

I hereby authorize Dr. Marc Feldman and Dr. David Rayfield to furnish information concerning my illness and treatment to any insurance carrier. I further assign Dr. Feldman and Dr. Rayfield all payments the insurance carriers are obligated to make on my behalf for services rendered.

I understand that my insurance may not cover all fees charged by the Doctor. I hereby agree to be responsible for all payments of the non-covered charges. If for any reason there is a balance owing on my account, I agree to pay promptly upon receipt of the monthly statement.

I certify that I have been informed that any preliminary authorization/precertification for payment obtained by Dr. Feldman and Dr. Rayfield's office is not a guarantee of payment as per my insurance company's guidelines.

I also acknowledge that interest will be added for any account that is not paid by my insurance or myself after 30 days, at an interest rate of 12% per year. I agree to pay all costs necessary to collect any unpaid balance including attorney fees. There will be a service charge of \$25 for returned checks.

Date: \_\_\_\_\_

Signature of Patient (Parent or Guardian)