

Patient Registration

Patient Name: _____

Sex: _____ S.S. #: _____ - _____ - _____ Date of Birth: ____/____/____ Age: _____

Address: _____ Apt: _____

City: _____ St: _____ Zip Code: _____

Home Phone: _____ Work: _____ Marital Status: S M D W

Cell Phone: _____ Pager #: _____

If patient is under 18, Parent/Legal Guardian Name: _____

Spouse Name: _____ Phone: _____

Primary Care Physician: _____ PCP Phone: _____

Referring Physician: _____ Ref. Phone: _____

Insured Information

*Primary Insurance Company: _____ Date of Birth ____/____/____

Insured Name: _____ Relation to Patient: _____

Insured S.S. # _____

*Secondary Insurance Company: _____ Date of Birth ____/____/____

Insured Name: _____ Relation to Patient: _____

All Insured Patients

Insurance Release and Assignment

I hereby authorize Dr. Michael C. Margulies to release to my insurance company or its representatives any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such medical or surgical care. I also authorize and request for my insurance company to pay directly to Dr. Margulies the amount due in my pending claim for medical and/or surgical treatment/services, by such reason of such treatment/services rendered to: _____.

Name of Patient

Signature of Patient or Parent/Guardian of Patient

Date of Signature

Medicare B Patients Only

Lifetime Signature Authorization

I authorize any holder or other information about me to release to the Social Security Administration and Health Care financing Administration or its intermediaries or carriers, or to the billing agent of Dr. Margulies any information needed for this or a related medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accept assignments.

Signature as it appears on Medicare Card

Date of Signature

Michael C. Margulies, M.D., P.A.

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