Print Form

KANER MEDICAL GROUP, P.A.

Patient Registration

PLEASE COMPLETE THE FOLLOWING:

Last Name: _____ First Name: _____ Initial: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Date of Birth: _____

S.S.#: _____ Sex (M / F): _____ Marital Status (M / S / D / W): _____

E-MAIL Address: _____ Whom may we thank for your Referral: _____

EMPLOYMENT

Company Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Ext: _____

INSURANCE SUBSCRIBER

_____ Spouse _____ Parent _____ Guardian

Last Name: _____ First Name: _____ Initial: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Date of Birth: _____

S.S.#: _____ Sex (M / F): _____ Marital Status (M / S / D / W): _____

Employer Name: _____

Employer Address: _____

City: _____ State: _____ Zip Code: _____

Employer Phone: _____ Ext: _____

Spouse's Name: _____ Work Phone: _____

Nearest Relative or Friend Not Living With You: _____

Relative / Friend Phone #: _____

INSURANCE

Company Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____

Policyholder Name: _____ Relationship: _____

Certificate #: _____ Group #: _____ Member #: _____

PLEASE REMEMBER insurance is considered a method of reimbursing the patient for fees paid to the physician, and is usually not designed to pay the entire fee. Because insurance companies vary in the amount they will pay for various services, it is ultimately your responsibility to pay the portion of the bill that is not paid by them (unless otherwise restricted by law or agreement that we have with the insurer).

IN ORDER TO HELP CONTROL THE COST OF BILLING, WE REQUEST THAT PAYMENT BE MADE FOR ALL SERVICES AT THE CONCLUSION OF YOUR VISIT UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE PRIOR TO SERVICES BEING RENDERED.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier or any other commercial insurance company, any information needed for this or a related medical claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits be made to KANER MEDICAL GROUP, P.A. Regulations pertaining to Medicare assignment of benefits apply.

_____

Patient Signature (Parent / Guardian if patient is a minor)

_____

Date