KANER MEDICAL GROUP, P.A.

CITY OF BEDFORD

Employee Registration

Please complete the following: Date ___________________

Last Name: ____________________ First Name: ______________________ Initial:_________

Address:____

City: ___________________________ State: _______________ Zip Code: ________________

Home Phone : ________________________ Cell Phone: _____________________________

Date of Birth: _____________________ SS#____________________ Sex (M/F): __________

Marital Status (M / S/ D/ W): _______ E-MAIL Address: ______________________________

Covered Dependents

Last Name: ____________________ First Name: ______________________ Initial:_________

Date of Birth: _____________________ SS#____________________ Sex (M/F): __________

Last Name: ____________________ First Name: ______________________ Initial:_________

Date of Birth: _____________________ SS#____________________ Sex (M/F): __________

Last Name: ____________________ First Name: ______________________ Initial:_________

Date of Birth: _____________________ SS#____________________ Sex (M/F): __________

Last Name: ____________________ First Name: ______________________ Initial:_________

Date of Birth: _____________________ SS#____________________ Sex (M/F): __________

Do you have a Primary Care Provider: Y / N____________ Office Phone: _________________

Primary Care Providers Name:____

Address: ____

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