REGISTRATION

RWIN R.ENDELMAN, M.D

(PLEASE PRINT)

Date: _____ Home Phone: _____

PATIENT INFORMATION

Name _____ Soc. Sec. # _____

Last Name First Name Initial

Address _____

City _____ State _____ Zip _____

Sex: ☐ M ☐ F Age _____ Birthday _____ ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Whom may we thank for referring you? _____

In Case of emergency who should be notified? _____ Phone _____

PRIMARY INSURANCE

Person Responsible for Account _____

Last Name First Name Intitial

Relation to Patient _____ Birthday _____ Soc.Sec. # _____

Address (if different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Insurance Company _____

Contact # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____ Relation to Patient _____ Birthday _____

Address (if different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Subscriber Employed by _____ Business Phone _____

Insurance Company _____ Soc.Sec. # _____

Contact # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____

Name of Insurance Company(ies)

and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered.

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature Relationship Date