REGISTRATION FORM

THIS FORM HAS TWO PAGES

FORM MUST BE COMPLETELY FILLED OUT. THE INFORMATION REQUESTED ON THIS FORM IS USED TO FILE MEDICAL CLAIMS AND FOR OTHER IMPORTANT MEDICAL DOCUMENTATION. PLEASE PRINT LEGIBLY SO THAT WE MAY ACCURATELY REFLECT YOUR PERSONAL INFORMATION IN ANY TRANSACTION WE MAY NEED TO MAKE ON YOUR BEHALF. THIS INCLUDES CALLING YOUR INSURANCE COMPANY, SENDING REQUISITIONS TO LABS, etc. THANK YOU

BREAST SPECIALTY CARE, PC

Specializing in Benign and Malignant Diseases of the Breast

PERSONAL INFORMATION

NAME: _____ IS THIS YOUR LEGAL NAME? ☐ YES ☐ NO

(If NO please print your legal name) _____

DATE OF BIRTH: / / | SEX: | SS# - / /

MAILING ADDRESS: _____

City - *State -* *Zip Code -*

PREFERRED PHONE:
☐ HOME ( ) _____
☐ CELL ( ) _____
☐ WORK ( ) _____

EMPLOYER: _____

EMAIL: _____

MARITAL STATUS: ☐ S ☐ M ☐ D ☐ W

SPOUSE / DOMESTIC PARTNER: _____

HOME PHONE: ( ) _____

WORK PHONE: ( ) _____

ETHNICITY & RACE *(Please check box that applies)*:

☐ AMERICAN INDIAN or ALASKA NATIVE ☐ HISPANIC/LATINO ☐ ASIAN ☐ BLACK or AFRICAN AMERICAN

☐ WHITE ☐ OTHER RACE

PREFERRED LANGUAGE: _____

REFERRING / PRIMARY PHYSICIAN

NAME: _____ PHONE: ( ) _____

ADDRESS: *City -* *State -* *Zip Code -* FAX: ( ) _____

PHYSICIANS I WOULD LIKE MY MEDICAL RECORDS TO BE SENT TO:

NAME: _____

ADDRESS: *City -* *State -* *Zip Code -*

PHONE: ( ) _____

FAX: ( ) _____

NAME: _____

ADDRESS: *City -* *State -* *Zip Code -*

PHONE: ( ) _____

FAX: ( ) _____

INFORMATION RELEASE

I AUTHORIZE MY HEALTH INFORMATION TO BE DISCUSSED WITH THE FOLLOWING PERSON, EITHER OVER THE PHONE OR IN THE OFFICE

NAME: _____ PHONE: ( ) _____

RELATIONSHIP TO PATIENT: _____

INSURANCE INFORMATION

"IN ORDER FOR OUR BILLING DEPARTMENT TO FILE A CLAIM ON YOUR BEHALF, THE INFORMATION ASKED HERE IS REQUIRED. WITHOUT THIS INFORMATION, WE WILL NOT BE ABLE TO BILL YOUR INSURANCE COMPANY, MAKING YOU A SELF-PAY-PATIENT"

PRIMARY INSURANCE: _____ MEMBER/POLICY #: _____

POLICY HOLDER NAME: _____ GROUP/PLAN: _____

POLICY HOLDER S.S. #: / / DOB: / / RELATIONSHIP TO PATIENT: _____

SECONDARY INSURANCE: _____ MEMBER/POLICY #: _____

POLICY HOLDER NAME: _____ GROUP/PLAN: _____

POLICY HOLDER S.S. #: / / DOB: / / RELATIONSHIP TO PATIENT: _____

IF THE PATIENT IS A MINOR *(UNDER 18)*

MOTHER: _____ ( ) _____

ADDRESS: _____ *City -* *State -* *Zip Code -*

MOTHER's D.O.B.: / / MOTHER's S.S. #: / /

FATHER: _____ PHONE: ( ) _____

ADDRESS: _____ *City -* *State -* *Zip Code -*

FATHER's D.O.B.: / / FATHER's S.S. #: / /

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IF THE PATIENT IS A MINOR *(UNDER 18 continued)*

POLICY HOLDER: _____ ( ) _____

ADDRESS: _____ *City -* _____ *State -* _____ *Zip Code -* _____

POLICY HOLDER S.S. #: ___/___/___ POLICY HOLDER D.O.B.: ___/___/___

NOTES:

"IN CASE OF EMERGENCY" - CONTACT INFORMATION

EMERGENCY CONTACT: _____ RELATIONSHIP _____

CONTACT PHONE: ( ) _____ ALTERNATE PHONE: ( ) _____

UNDERSIGNED

I THE UNDERSIGNED, CERTIFY THAT I (OR MY DEPENDENT) HAVE INSURANCE COVERAGE WITH THE INSURANCE COMPANY(S) LISTED ON THE FRONT OF THIS FORM AND ASSIGN DIRECTLY TO ***BREAST SPECIALTY CARE, PC*** ALL INSURANCE BENEFITS IF ANY, OTHERWISE PAYABLE TO DR. SEEDMAN 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.

_____ DATE: ___/___/___

(PRINT NAME OF RESPONSIBLE PARTY)

_____ DATE: ___/___/___

(SIGNATURE OF RESPONSIBLE PARTY)

WE CHARGE A **$50.00** FEE FOR ESTABLISHED PATIENTS & **$100.00** FEE FOR NEW PATIENTS IF WE ARE **NOT NOTIFIED** OF A CANCELLATION WITHIN 24 HOURS OF YOUR SCHEDULED APPOINTMENT. ***INITIAL*** _____

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