

FOR OFFICE USE ONLY:

New ___ Update ___ Dr.S / Dr.B

Today's Date _____

PATIENT INFORMATION

Legal First Name _____
Legal Last Name _____ Middle Initial _____
Maiden or other Name(s) used: _____
Street Address _____
City _____ State _____ Zip Code _____
Employed (Y/N) ___ Occupation _____
Employer Name _____
Employer Address _____

Home Phone _____
Work Phone _____
Cellular Phone _____
Email address _____
Date of Birth _____ Age _____
Gender (M/F) _____
Marital Status (circle one) Single Married Other
Primary Care Doctor _____
Referred by (name) _____

(circle one) DOCTOR, FRIEND, RELATIVE, PHONE BOOK,
INSURANCE BOOK, INTERNET

Emergency Contact (name) _____ Relationship _____
Phone (daytime) _____ Alt. Phone _____

PRIMARY INSURANCE CARRIER:

Name of Insurance Company _____
Address _____
Name of Insured Person _____
Sex (M/F) ___ Birth Date _____
Address _____
Employer _____
Patient's relationship to insured person: (circle one) self wife
husband child parent other

(circle one)
Deductible? Yes/No Amount \$ _____
Subscriber/Policy # _____
Group # _____
Phone _____
Occupation _____

SECONDARY INSURANCE CARRIER:

Name of Insurance Company _____
Address _____
Name of Insured Person _____
Sex (M/F) ___ Birth Date _____
Address _____
Employer _____
Patient's relationship to insured person: (circle one) self wife
husband child parent other

(circle one)
Deductible? Yes/No Amount \$ _____
Subscriber/Policy # _____
Group # _____
Phone _____
Occupation _____

*Other Insurance _____

PATIENT RESPONSIBILITY STATEMENT:

I understand that I am fully responsible for any indebtedness incurred for treatment for myself or my dependents. I further understand that insurance billing is a courtesy extended to me by my physician and any problems which may arise are between myself and my insurer. I am aware that any charges not covered by my insurance company are my personal financial responsibility. I authorize the release of any medical or other information necessary to process my claim(s). I also authorize assignment of payment(s) to Marc Silverstein, MD & Sheila M. Braunstein, MD, Inc. Furthermore, I understand that I may be subject to a (\$25.00) charge for appointments missed without prior notice.

Signature of Patient / Responsible Party

Date

IF THE PATIENT IS UNDER AGE 18:

I am the parent or legal guardian of this patient and I consent to diagnosis and treatment rendered by Dr. Marc Silverstein and/or Dr. Sheila Braunstein.

Signature of Responsible Party

Date