

PATIENT INFORMATION

PLEASE PRINT CLEARLY

Last Name _____ First Name _____ MI _____

Address _____ Social Security # _____

City _____ State _____ Zip _____

Home Phone (____) _____ Business Phone (____) _____

Date of Birth _____ Age _____ Sex _____ M _____ F

Employer _____ Occupation _____

Family Physician _____ Phone # _____

Referring MD _____ Phone # _____

Insurance Information

Primary Insurance:

Insurance Company Name _____

Insurance ID # _____ Group # _____ Plan # _____

Card Holder's Name _____ Relationship to Patient _____

Secondary Insurance:

Insurance Company Name _____

Insurance ID # _____ Group # _____ Plan # _____

Card Holder's Name _____ Relationship to Patient _____

Reason for visit: _____

Release and Assignment:

I hereby authorize Dr. Ira Bernstein to release to my insurance company information concerning my illness and hereby assign to the above all payments for medical services rendered to myself or my dependent. I understand that I am responsible for any amount not covered by insurance. I consent to treatment of my condition as indicated by my medical history and the doctor's diagnosis.

Patient/Guardian Signature: _____ Date: _____