

Charles Rosenthal OD

PRE-VISIT REGISTRATION FORM

<i>In order to serve you properly we will need the following (please print)</i>			
PATIENT'S NAME:	Sex: M F	Birthdate:	Age:
PATIENT Soc. Sec. #:	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widow <input type="checkbox"/> Divorced		
Florida Residence Address:	City	State	Zip
			Home Phone:
If child: Indicate name of parent(s) or guardian: Relationship:			
ARE YOU A YEAR-ROUND RESIDENT OF FLORIDA?: YES NO If not, please circle the months you reside in Florida -		JAN FEB MAR APR MAY JUN JLY AUG SEP OCT NOV DEC	
Northern/Other Address:	City	State	Zip
			Northern Phone:
Name of Employer:	Employer Address:		Work Phone:
Spouse's Name:	Spouse's Birthdate:	Spouse's Soc. Sec.#:	Spouse's Occupation:
Do you have medical insurance? YES NO	How do you intend to pay for today's fee? <input type="checkbox"/> Cash <input type="checkbox"/> Check <input type="checkbox"/> Credit Card <input type="checkbox"/> Workmen's Comp.		
PRIMARY Insurance Company - COMMERCIAL MEDICARE Name / Address / Telephone #:			
Are you retired? YES NO If so, is Medicare your Primary Insurance? YES NO			
Retirement Date (Month/Yr):			
Subscriber Name:	I. D. #:	Certificate No:	Relationship to patient: Is insurance through employer? YES NO
SECONDARY Insurance Company Name / Address / Telephone #:			
Cardholder's Name:	Policy No:	Group No:	Relationship to patient: Is insurance through employer? YES NO
IN CASE OF EMERGENCY: Name of friend/relative NOT residing with you:			
		Relationship:	Phone Number:
FAMILY PHYSICIAN (name & address):			Phone Number:
Whom may we thank for referring you to this office?			

LIFETIME AUTHORIZATION

I authorize reports of my evaluation, treatments and any follow up evaluations to be sent to my referring doctor, the doctor requesting consultation, my family physician, as well as any other health care providers, hospitals or outpatient facilities that have or will identify to you.

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 carriers, or to the billing agents of my insurance companies or to my employer if this is a workmen's compensation claim, any information needed for this or a related insurance or Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to myself or to the party who accepts assignment. If I have been tested for or have contracted Autoimmune Deficiency syndrome (AIDS) /Human Immunodeficiency virus HIV, I authorize the release of the fact and/or results of testing to any of the individuals, health care providers or third party payors related to my care. (we do not provide or perform testing for the virus).

I understand that I am fully and legally responsible for all billing charges of this account which includes all outstanding balances not covered by Medicare and/or insurance companies. In the event that I fail to pay any outstanding balance, I also agree to pay all costs of collection agency fees, attorney fees and court costs, if any.

GUARANTOR SIGNATURE: _____ (Responsible for payment of Account)

DATE: _____