STEPHEN J. CLARK M.D.,P.C. Patient Registration Form

Patient Name _____
(Legal) Last Name (Legal) First Name Middle

Patient Goes By Nickname _____

Address _____

City _____ State _____ Zip _____

Phone (cell) _____ (home) _____

Sex _____ Birthdate _____ SS# _____ Marital Status _____

**Emergency Contact Name _____ Phone _____

Responsible Party Name _____ Birth date _____

Address _____ City _____ State _____ Zip _____

Employer Name (resp. party) _____ Address _____

Phone (w) _____ Responsible Party SS# _____

Primary Insurance Carrier _____ HMO ____ PPO ____ POS ____ Other ____

ID# _____ Group/Plan # _____ Insured Name _____

Relationship to Insured: ____Self ____Spouse ____Child ____Other Insured DOB_____

Affiliation: ( ) NSU-Highland Park Hospital ( ) Northwestern Lake Forest Hospital

Secondary Insurance Carrier: _____ ID# _____

Group/Plan# _____Insured Name _____ Insured DOB_____

Who referred you to our office? _____

Assignment & Release

I assign directly to Drs. *Clark/Kharasch* all medical 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 authorized the doctor to release all medical information necessary to secure the payment on all my insurance submissions. I am responsible for all non sufficient fund checks returned with an additional $35 fee.

_____ _____
Signature of Insured/Guardian/Patient Today's Date

Medicare Authorization

I request that payment of Medicare benefits be made on my behalf to Drs. *Clark/ Kharasch* for any services furnished by that physician. I authorize any holder medical information about me to release to the Health Care Financing Administration & its agents any information needed to determine these benefits payable. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 on the HCFA-1500 form submitted manual or electronic, my signature authorized release of information to the insurer or agency shown. I understand I am responsible for deductible, coinsurance and noncovered services.

_____ _____
Signature of Beneficiary/Patient Today's Date

THIS FORM WILL EXPIRE 1 YEAR FROM TODAY'S DATE, NEW FORMS WILL NEED TO BE COMPLETED.