**PATIENT REGISTRATION**
PLEASE PRINT CLEARLY

Account Number:

NAME: _____ SEX M ( ) F( )
(LAST) (FIRST) (MIDDLE)

BIRTHDATE:_____ AGE:_____ MARITAL STATUS:_____

HOME ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____ HOME PHONE: (_____)_____

SOCIAL SECURITY #:_____ EMPLOYER:_____OCCUPATION:_____

EMPLOYER'S ADDRESS:___ _____

CITY:_____ STATE:_____ ZIP:_____ WORK PHONE: (_____)_____

EMERGENCY CONTACT:_____ PHONE: (_____)_____

REASON FOR VISIT:_____

WHO REFERRED YOU?_____ NEXT APPOINTMENT DATE: _____

**INSURANCE INFORMATION**

**WORK INJURY? YES ( ) NO( ) AUTO INJURY? YES ( ) NO( )**

**PRIMARY INSURANCE**:_____ PHONE: (_____)_____

ADDRESS:_____

GROUP NAME:_____ GROUP #:_____ POLICY #:_____

SUBSCRIBER/POLICY HOLDER NAME:_____
(LAST) (FIRST) (MIDDLE)

SUBSCRIBER SS#:_____ SUBSCRIBER DATE OF BIRTH:_____

SUBSCRIBER RELATIONSHIP TO PATIENT: (Circle One): SELF SPOUSE PARENT GUARDIAN OTHER

DO YOU BELONG TO A MEDICARE HMO?(Circle One) YES NO IF YES, NAME OF HMO:_____

**SECONDARY INSURANCE**:_____ PHONE: (_____)_____

ADDRESS:_____

GROUP NAME:_____ GROUP #:_____ POLICY #:_____

SUBSCRIBER/POLICY HOLDER NAME:_____
(LAST) (FIRST) (MIDDLE)

SUBSCRIBER SS#:_____ SUBSCRIBER DATE OF BIRTH:_____

SUBSCRIBER RELATIONSHIP TO PATIENT: (Circle One): SELF SPOUSE PARENT GUARDIAN OTHER

**PLEASE COMPLETE IF YOUR INJURY IS WORK RELATED**

**WORK COMP INSURANCE**:_____ CLAIM #:_____

DATE OF INJURY:_____ EMPLOYER **AT THE TIME OF INJURY**:_____

WORK COMP. PHONE:_____ CASE MANAGER:_____

BILLING ADDRESS:_____

**PLEASE COMPLETE IF YOU HAVE HIRED AN ATTORNEY REGARDING THIS INJURY**

ATTORNEY NAME:_____ ATTORNEY PHONE: (_____)_____

ATTORNEY ADDRESS:_____

**BRADLEY H. CHESLER, M.D.**

**FINANCIAL RESPONSIBILITY: I understand that I am financially responsible for all charges for services rendered to me, including the full balance remaining after payment of my insurance benefits. I am aware of a $20.00 processing fee of all returned checks and that I am responsible for its payment.**

**SIGNED:_____ DATE:_____**

**ACCURATE, VALID AND TIMELY INSURANCE INFORMATION: I understand that I am responsible for providing accurate and valid insurance information and that I am responsible for my charges if my insurance is not in effect or is invalid on the date that services are provided. I understand that if I have an insurance plan that requires prior authorization and I do not provide the office with complete insurance information a minimum of one week prior to receiving services, I may be financially responsible for services that are not authorized by the insurance company.**

**SIGNED:_____ DATE:_____**

**ASSIGNMENT OF BENEFITS: I authorize payment of all medical insurance benefits for medical services rendered by Bradley H. Chesler, M.D. directly to Bradley H. Chesler, M.D., A Professional Corporation. It is understood that any money received from insurance benefits over and above my indebtedness to Bradley H. Chesler, M.D. will be refunded to the appropriate insurance company.**

**SIGNED:_____ DATE:_____**

**CONDITION IS NOT DUE TO WORK INJURY, AUTOMOBILE ACCIDENT, OR BODILY INJURY: My injuries ARE NOT the result of a work injury, automobile accident or bodily injury that is covered by a third party or is under legal dispute. I AM NOT working with an attorney to obtain reimbursement for my medical treatment. I understand that I may be financially responsible for payment of my charges if failure to notify the office of this information results in a denial of payment by my private insurance and the office is not responsible to resubmit billing to another party after collecting from the private insurance company.**

**SIGNED:_____ DATE:_____**

**CONDITION IS DUE TO WORK INJURY, AUTOMOBILE ACCIDENT, OR BODILY INJURY AND MAY BE THE RESPONIBILITY OF A THIRD PARTY: I have notified the office if my injuries are the result of a work injury, automobile accident, or bodily injury that may be covered by a third party. I have notified the office even if causation and responsibility is under review.**

**SIGNED:_____ DATE:_____**

**RELEASE OF INFORMATION: I authorize the release of any information necessary to process this claim.**

**SIGNED:_____ DATE:_____**

**MEDICARE PATIENTS ONLY:I understand that I will be billed and that I am financially responsible for all charges allowable by Medicare, but not paid by Medicare for medical services rendered. I understand that I am not responsible for charges in excess of Medicare's allowable amount.**

**SIGNED:_____ DATE:_____**