PATIENT INFORMATION REGISTRATION FORM

(Please print clearly)

Patient Full Name (Last,First):____ DOB:__________________
Female ___ Male___ Other___ Maried___ Single___ Divorced___ Separated___ Widowed___
Address:_______________________________ City:_________________________ State:_________ Zip:___________
Home Phone:____________________________ Cell Phone:_____________________Email:______________________

Patient's Employer:___________________________________ Patient Occupation:_____________________________
Address:_____________________________________ City:____________________ State:________ Zip_____________

Spouse:____ Occupation:______________________________________
Spouse's Employer:____ Phone:____________________________
Address:____________________________________ City:____________________ State:_________ Zip:___________

In case of emergency, contact (other than spouse):____
Address:___________________________________ City:_____________________ State:________ Zip:___________
Relationship:____ Phone:______________________________________

Primary Care Physician:____________________________ Phone:___________________ Fax:__________________
Address:____________________________________ City:____________________ State:_________ Zip:___________
Other Physicians:____
Pharmacy Phone:____

Referral Information(please tell us how you were referred to our practice)

Physician:_______________________ Address:_____________________ Phone:______________ Fax:_____________
Health Plan:_______________________________________ Other Source:____________________________________

Insurance Information

Primary Insurance:_____________________ Policy No.:__________________________ Group No.:_________________
Subscriber:____ Effective Date:_____________________

Secondary Insurance:_____________________ Policy No.:__________________________ Group No.:_______________
Subscriber:____ Effective Date:_____________________

We Ask all patients to show their insurance or managed care membership card so that we may make copies of them.

We cannot render services on the assumption that our charges will be paid by an insurance company. All services will be charged directly to the insurance but the patient remains personally responsible for payment.

Payment Authorization

I, ______________________________________, hereby authorize SANIJA BAJRAMOVIC, M.D. to furnish information concerning my present illness. I direct the insurer to pay, without equivocation, directly to the physician, all benefits due her as a result of this claim. Although covered by insurance, I am aware that I am personally responsible for all charges. A photostatic copy of this authorization will be valid as the original.

Signature of Patient:____ Date:________________