JEFFREY ZURAVLEFF, M.D., P.C.

PATIENT REGISTRATION FORM

Today's Date:_________________

Patient's Name: ____
Last First Middle

Address: ____
and Street Apt # City State Zip

Home phone : ________________**cell :** ________________ **work :** ___________________

E-Mail address:______________________________ **Gender:**______________________

Date of Birth: ___/___/ _______ **Social Security Number:** __________________________

Employer : ______________________ Employer's phone # : _________________________

Employer's address : ____

Name of Spouse or Parent : ____

Spouse/Parent's phone # : __________________ Spouse/Parent's date of birth :_____________

Emergency contact : ____
Name Relationship

Home phone # : __________________________ Work phone # : _______________________

Insurance information

Primary insurance : ______________________________ ID # _______________________
Group # ___________________

Secondary insurance : ____________________________ ID # _______________________
Group # ___________________

Patient relationship to insured : Self ____ Spouse ____ Child ____

Insurer's name : ________________________ Address : ___________________________

Social Security Number : ___________________ Employer : ________________________

All professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance claims but the patient is responsible for all fees, co-payments, and deductible regardless of insurance coverage. In the event that it becomes necessary to refer your account to an attorney or collection agency, the undersigned agrees to pay all attorney and collection agency fees associated with the collection process.
I authorize Jeffrey J. Zuravleff, M.D., P.C. to release any medical information necessary to pay my insurance claims and I authorize payment to such benefits to Jeffrey J. Zuravleff, M.D., P.C.

Signature: __________________________________ Date : ____/____/_________

We accept cash and personal checks