

# PATIENT REGISTRATION

HOW WERE YOU REFERRED TO DR. DOBOZIN? \_\_\_\_\_

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ MI \_\_\_\_\_  
ADDRESS \_\_\_\_\_ APT. #(required): \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
CELL PHONE ( ) \_\_\_\_\_ EMAIL ADDRESS: \_\_\_\_\_  
HOME PHONE ( ) \_\_\_\_\_ WORK PHONE ( ) \_\_\_\_\_  
DATE OF BIRTH \_\_\_\_\_ SEX \_\_\_\_\_ SS# \_\_\_\_\_  
RELATION TO INSURED: \_\_ SELF \_\_ SPOUSE \_\_ CHILD \_\_ OTHER  
MARITAL STATUS: \_\_ MARRIED \_\_ SINGLE \_\_ WIDOWED \_\_ DIVORCED \_\_ SEPARATED  
OCCUPATION \_\_\_\_\_  
EMPLOYER \_\_\_\_\_

## RESPONSIBLE PARTY (PERSON WHO IS THE INSURED)

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ MI \_\_\_\_\_  
ADDRESS \_\_\_\_\_ APT. #(required): \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
HOME PHONE ( ) \_\_\_\_\_ WORK PHONE ( ) \_\_\_\_\_  
CELL PHONE ( ) \_\_\_\_\_  
DATE OF BIRTH \_\_\_\_\_ SEX \_\_\_\_\_ SS# \_\_\_\_\_  
OCCUPATION \_\_\_\_\_ EMPLOYER \_\_\_\_\_

**PRIMARY CARE PHYSICIAN:** NAME: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
CITY/STATE/ZIP: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Phone: ( ) \_\_\_\_\_ [NPI: \_\_\_\_\_ ]

## RESPONSIBLE PARTY'S INSURANCE INFORMATION

**PRIMARY INSURANCE CO.** \_\_\_\_\_

**POLICY #** \_\_\_\_\_

**GROUP #** \_\_\_\_\_

**COPAY:** \_\_\_\_\_

**SECOND INSURANCE CO. (If no 2<sup>nd</sup> insurance: write "none")** \_\_\_\_\_

**POLICY #** \_\_\_\_\_

**GROUP #** \_\_\_\_\_

**COPAY:** \_\_\_\_\_

### AUTHORIZATION TO RELEASE INFORMATION & ASSIGNMENT OF INSURANCE BENEFITS

I AUTHORIZE THE RELEASE OF ALL MEDICAL INFORMATION NECESSARY TO PROCESS CLAIMS, INCLUDING BY ELECTRONIC MEANS IF AVAILABLE AND REQUEST BENEFITS BE PAID TO: DR. DOBOZIN. I ALSO UNDERSTAND THAT I WILL BE RESPONSIBLE FOR ANY DEDUCTIBLES AND/OR COPAYS APPLIED BY THE INSURER.

**Sign Here: X** \_\_\_\_\_

SIGNATURE

\_\_\_\_\_ DATE