



PATIENT REGISTRATION

Name _____

Address _____
(Street) (City) (State) (ZIP)

Phone: H _____ W _____ Cell _____

Email: _____ May we contact you by email? yes no

Emergency Contact (Name & phone) _____

Parents' names (if minor) _____

Age _____ Date of Birth _____ Sex _____ Marital Status _____

Profession _____

Reason for visit: _____

How were you referred to our practice? _____

Insurance: _____

Insured's Name _____ Insured's SS# _____

Subscriber number _____ Group number _____

Insured's Employer _____ Insured's date of birth _____

FINANCIAL POLICY:

BASIC POLICY: Payment in full is due at the time service is provided in our office.

DEDUCTIBLE/COPAY: You will be responsible for any deductible or copay charged by the insurance company.

ASSIGNMENT OF INSURANCE BENEFITS Patients with insurance please read and sign below.

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans, to **Nina S. Naidu, MD, PC**. I understand I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment. **The patient is ultimately responsible for all professional fees.**

Patient or Authorized Representative

Date