

Peter S. Schwartz, MD

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REGISTRATION FORM

PATIENT INFORMATION (Please Print)

Patient's First Name:		Middle:	Last:	
Today's Date:		Primary Care Physician:		
Birth date: / /		Age:	Social Security Number:	
<input type="checkbox"/> Male <input type="checkbox"/> Female		Email address:		
Street address:				
City:		State:	ZIP Code:	
Home phone: ()		Work phone: ()	Cell phone: ()	
Patient's Employer:				
Mailing Address:				
How did you hear about us? (please check one box)				
<input type="checkbox"/> Dr. (Please specify)		<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Hospital	<input type="checkbox"/> Family
<input type="checkbox"/> Other (Please specify)	<input type="checkbox"/> Newspaper (Please specify)	<input type="checkbox"/> Close to home / work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Friend
Other family members seen here:				

INSURANCE INFORMATION (Please give your insurance card to the receptionist AND complete this section.)

Primary Insurance:		Subscriber's Name:		
Policy or ID Number:		Group Number:	Office Copay \$	
Subscriber's Birth date: / /		Subscriber's Social Security Number:		
Mailing Address of insurance company:				
Subscriber's Employer:			Employer phone: ()	
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other (please indicate):				

Secondary Insurance:		Subscriber's Name:		
Policy or ID Number:		Group Number:		
Subscriber's Birth date: / /		Subscriber's Social Security Number:		
Mailing Address of insurance company:				
Subscriber's Employer:			Employer phone: ()	
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other (please indicate):				

IN CASE OF EMERGENCY

Name:	Relationship to patient:	Daytime Phone: ()
Address:		

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance remaining on my account after insurance payment or the entire balance if I have no insurance. I also authorize Dr. Peter Schwartz or my insurance company to release any information required to process my claims.

Patient / Guardian signature:	Date:
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