

**BERNSTEIN
ALLERGY GROUP, INC.**

REGISTRATION FORM
(PLEASE PRINT ALL INFORMATION)

INSURANCE INFORMATION

PATIENT INFORMATION

NAME _____

ADDRESS _____

CITY, STATE, ZIP _____

HOME PH _____ CELL _____

WORK _____ EXT _____

EMAIL _____

SEX M / F DATE OF BIRTH _____

SOC. SEC# _____ - _____ - _____

SINGLE MARRIED WIDOWED DIVORCED

EMPLOYER'S NAME _____

EMPLOYER'S PHONE _____

PRIMARY INSURANCE

INSURANCE CO _____

CLAIMS ADDRESS _____

PHONE _____

INSURED'S NAME _____ M / F

DATE OF BIRTH _____ SS# _____

PATIENT RELATIONSHIP TO INSURED _____

EFFECTIVE DATE OF POLICY _____

POLICY ID# _____

GROUP# _____

EMPLOYER _____

SECONDARY INSURANCE

INSURANCE CO _____

CLAIMS ADDRESS _____

PHONE _____

INSURED'S NAME _____ M / F

DATE OF BIRTH _____ SS# _____

PATIENT RELATIONSHIP TO INSURED _____

EFFECTIVE DATE OF POLICY _____

POLICY ID# _____

GROUP# _____

EMPLOYER _____

ASSIGNMENT OF BENEFITS

I hereby assign all medical / surgical benefits to which I am entitled, including Medicare, private insurance, major medical and any other participating plans to: Bernstein Allergy Group, Inc. This will remain in effect until revoked by me in writing. A photocopy is to be considered as valid as an original. I authorize release of any pertinent information to my insurance company as requested to secure payment.

I UNDERSTAND THAT I AM RESPONSIBLE FOR DETERMINING IF A MEDICAL SERVICE OR REFERRAL TO ANOTHER PROVIDER IS COVERED BY MY INSURANCE.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES NOT PAID BY MY INSURANCE.

REFERRING PHYSICIAN

PHYSICIAN NAME _____

ADDRESS _____

PHONE _____ FAX _____

HOW DID YOU HEAR ABOUT US?

FAMILY FRIEND PHYSICIAN PHONE BOOK

ADVERTISEMENT OTHER _____

EMERGENCY INFORMATION

EMERGENCY CONTACT _____

HOME PH _____ WORK _____

CELL _____ RELATIONSHIP _____

RESPONSIBLE PARTY (IF DIFFERENT FROM PATIENT)

NAME _____

ADDRESS _____

CITY, STATE, ZIP _____

SOC. SEC# _____ - _____ - _____

EMPLOYER _____

OFFICE POLICY REQUIRES A PARENT OR LEGAL GUARDIAN BE PRESENT FOR MINOR (UNDER AGE 18) TO BE TREATED.

SIGNATURE

DATE

SIGNATURE

DATE