PATIENT REGISTRATION FORM

Raphlan Medical Associates

Raphael D Lanade, M.D.

Patient Last Name: _____ First Name _____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____

Employer: _____ Work Phone: _____

S.S. #: _____

Emergency Contact: _____ Phone #: _____

Spouse Name: _____ S.S #: _____

Patient Employer/ School: _____ Occupation: _____

Employer/ School Address: _____

Email _____

Primary Insurance

Person responsible for account: _____

Relationship to Patient: _____ Birthdate: _____ S.S. #: _____

Address (if different from pt.): _____ Phone: _____

City: _____ State: _____ Zip: _____

Person Responsible Employed By: _____ Occupation: _____

Business Address: _____ Business Phone: _____

Insurance Company: _____

Contract #: _____ Group #: _____ Subscriber #: _____

Are you covered by any additional insurance? _____

Assignment and Release

I certify that I and/or me dependent(s), have insurance coverage with _____ and assign directly to Dr. Raphael D. Lanade all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all other charges whether or not paid by my insurance. I authorize the use of my signature on all insurance submissions. The above named doctor may use my health care information and may disclose such information to the above named insurance companie(s) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Should the account be referred to an attorney or collection agency for collection, the undersigned agrees to pay all cost of collection (including a reasonable attorney's fee, agency fee, and other collection expenses).

By signing below I authorize that I have read and received a copy of the notice of Privacy Practices provided by Raphlan Medical Associates.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date