GARY J. ROSENBAUM, M.D., P.A.

Home Phone:________________________________ Today's Date:_________________________

PATIENT INFORMATION

Name____Soc. Sec. #___________________________

Last Name First Name Initial

Address____

City____ State________________________ Zip______________________________

Cell Phone____________________ E-mail____ Fax #_______________________

Single_____ Married_____ Widowed_____ Separated_____ Divorced_____ Sex M_____ F_____ Birthdate_________________

Patient Employed by____

Business Address____

By whom were you referred?____

In case of emergency who should be notified____ Phone_______________________

Name Relationship to patient

PRIMARY INSURANCE

Person Responsible for Account____

Last Name First Name Initial

Relation to Patient_____________________ Birthdate____________________ Soc. Sec.#___________________________________

Address (if different from patient)____

City____ State________________________ Zip______________________________

Person Responsible Employed by____

Business Address____ Business Phone__________________

Insurance Company____

Contract #________________________ Group #_________________________ Subscriber Name______________________________

Name of other dependents covered under this plan____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? _______ Yes _________ No

Subscriber Name_____________________________________ Relation to Patient____________________ Birthdate______________

Address (if different from patient)____ Phone_________________________________

City____ State________________________ Zip______________________________

Subscriber Employed by____

Business Address____ Business Phone________________________________

Business Address____ Business Phone__________________

Insurance Company____

Contract #________________________ Group #_________________________ Subscriber Name______________________________

Name of other dependents covered under this plan____

ASSIGNMENT AND RELEASE

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some company pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, coinsurance, or any other balance not paid for by your insurance.

IN ORDER TO CONTROL YOU COST OF BILINGS, WE REQUEST THAT OUR CHARGES FOR OFFICE VISITS BE PAID AT THE CONCLUSION OF EACH VISIT. If the account is assigned to an attorney for collection and/or suit, the practice shall be entitled to reasonable attorney's fees and costs of collection.

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled including Medicare, private insurance and other health plans to the practice named above. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand I am financially responsible for all charges whether or not paid by said insurance.

SIGNED:____ Date_______________________