Greenfield, M.D. and Associates, P.A.

New Patient Registration

Name: _____ Sex: _____

DOB: ____/_____/_____ SSN:_____ Marital Status: _____

Home Address: _____

_____

Home Phone: _____ Cell: _____

Email: _____

Emergency Contact: _____

Relationship: _____ Phone: _____

Address: _____

_____

Insurance and Billing Information

Primary Insurance: _____

ID/Policy # _____ Group #_____

Insurance Company Phone: _____

Secondary Insurance: _____

ID/Policy # _____ Group # _____

Insurance Company Phone: _____

I, _____, hereby authorize Greenfield, M.D. and Associates, P.A. to apply for benefits on my behalf for covered services rendered. I request payment from Medicare, and/or _____ Insurance Company, be made directly to Greenfield, M.D. and Associates, P.A.

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim, to the above named billing agent and/or the insurance company named above. I permit a copy of this authorization to be used in place of the original.

Signature: _____ Date: _____