

David M. Kaufman, MD

Patient Registration

Name _____ SS# _____

Street Address _____ Date of Birth _____ Marital Status: S M W Sep D

City _____ State _____ Zip _____

Telephone: Home _____ Office _____

Referred by _____

Spouse's name _____

Spouse's Employer/ Address _____

Emergency Contact _____ Tel# _____ Relationship _____

Email Address _____

Patient Employer Information

Employer Name _____ Tel # _____

Employer Street Address _____ City/State _____ Zip _____

Patient's Occupation _____

Insured Person (If not patient)

Name _____ Tel # _____

Street Address _____ City/State _____ Zip _____

Relationship to Patient _____

Insurance

Medicaid # (if applicable) _____ Medicare # (if applicable) _____

Primary Insurance Company Name _____

ID# _____ Group # _____ Tel # _____

Secondary Insurance Company Name _____

ID# _____ Group # _____ Tel # _____

Information and Assignment of Benefits

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

Date _____ Signature _____

I hereby authorize Dr. _____ to apply for benefits on my behalf for covered services rendered by him /her, or by his/ her order. I request that payment from my insurance company be made directly to Dr. _____ (or to the party who accepts assignment).

I certify that the information I have reported with regard to my insurance coverage is correct.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

Date _____ Signature _____
(patient, parent, or guardian)