Jeffrey S. Feldman, MD, PC

Patient Registration Form

Children's Information: *Sex* *Insurance Suffix*

Last name _____First_____ Date of Birth_____/_____/_____ M / F ( )

Last name _____First_____ Date of Birth_____/_____/_____ M / F ( )

Last name _____First_____ Date of Birth_____/_____/_____ _M / F ( )

Last name _____First_____ Date of Birth_____/_____/_____ _M / F ( )

Street Address_____

City_____State_____ZIP_____

Primary Contact Telephone # ( ) _____ -- _____

Mother's Information: Last name_____First_____

Date of Birth _____/_____/_____ Soc.Sec. # _____-_____-_____

Address if different from child _____

City_____ State _____ZIP _____

Home Phone ( ) _____--_____ Work Phone ( ) _____--_____

Cell phone ( ) _____--_____ E-mail_____

Father's Information: Last name_____First_____

Date of Birth _____/_____/_____ Soc.Sec. #_____-_____-_____

Address if different from child_____

City _____State_____ ZIP_____

Home Phone ( ) _____--_____ Work Phone ( ) _____--_____

Cell phone ( ) _____--_____ E-mail _____

Insurance Information: Insurance Company _____

Subscriber Name _____ Policy or Card Number _____

Employer Name _____

Secondary Insurance Information: Insurance Company _____

Subscriber Name _____ Policy or Card Number _____

Employer Name _____

Authorization for Release of Medical Information and assignment of benefits:

- I authorize payments of authorized insurance benefits to Dr. Jeffrey Feldman, (JSFMDPC)
- Health insurance claims are submitted by this office. In the event your insurance company denies your claim, you are responsible for the balance.
- I authorize the release of any medical information needed to process my child's/children's claims.
- I understand that I am financially responsible for all charges whether or not paid by insurance.
- All office visit fees are due at the time of service. If applicable, insurance companies will be billed, however, copays, deductibles and coinsurances are due at the time of the visit.
- JSFMDPC expects full payment within 30 days of the receipt of a bill for services. In cases of financial hardships, payment plans can be requested.
- In the event that this account is turned over to an agency for collection of delinquent charges, I agree to pay all costs associated with collection of the outstanding charges.

Signature _____ Date _____