

**PATIENT REGISTRATION**

Patient's Name: Last \_\_\_\_\_, First \_\_\_\_\_ Middle Initial \_\_\_\_\_  
Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone # (\_\_\_\_) \_\_\_\_\_ Work Phone # (\_\_\_\_) \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Cell Phone# \_\_\_\_\_  
Sex: Male Female Marital Status: Single Married Widowed Divorced  
Social Security Number: \_\_\_\_\_ Driver's License Number: \_\_\_\_\_  
Referred By: \_\_\_\_\_ Personal Physician: \_\_\_\_\_

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**RESPONSIBLE PARTY:**

(circle one) SPOUSE OR PARENT, OTHER \_\_\_\_\_

NAME: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
Last First Middle  
ADDRESS (If Different ) \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
HOME PHONE # \_\_\_\_\_ WORK PHONE# \_\_\_\_\_  
SOCIAL SECURITY NUMBER \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

**\*EMPLOYER OF INSURED PERSON OR PARENT:**

\_\_\_\_\_  
Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Name of College \_\_\_\_\_ Student Status - Full Time \_\_\_\_\_ Part Time \_\_\_\_\_

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**THIS OFFICE BILLS YOUR INSURANCE COMPANY AS A COURTESY TO YOU. IF YOU DO NOT HAVE INSURANCE CARDS, PAYMENT IS DUE IN FULL AT THE TIME SERVICES ARE RENDERED AND YOU WILL BE RESPONSIBLE TO FILE YOUR OWN CLAIMS.**

**AUTHORIZATION TO RELEASE INFORMATION and ASSIGNMENT OF BENEFITS**

I hereby authorize Dr. Abraham Lotan or Dr. Joseph Scianna to apply for benefits on my behalf for covered services rendered by him or by his order. I request that payment from my insurance company be made directly to Dr. Lotan or Dr. Scianna. I understand that I will be financially liable for all non-covered charges not paid by my insurance carrier. 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 original. This authorization may be revoked by either me or my insurance company at any time in writing.

**COPAY IS DUE AT TIME OF SERVICES**

DATE: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_ Patient / Guarantor