Pinkas E. Lebovits, M.D., P.C.

REGISTRATION

Patient's Last Name: _____ First Name: _____ MI: _____

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Other Social Security Number: _____

Date of Birth: _____ Sex: ☐ Male ☐ Female Preferred Language : _____

Race: _____ ☐ Decline to Specify Ethnic Group: ☐ Hispanic or Latino ☐ Non Hispanic ☐ Decline

Emergency Contact: _____ Phone Number: _____

Spouse: _____ Phone Number: _____

Home Phone: _____ Work: _____ Mobile: _____

Email Address: _____ Preferred Method of Contact: ☐ Home # ☐ Mobile #

Street Address: _____ Apt: _____

City: _____ State: _____ Zip: _____ Country: _____

Employer's Name: _____ Occupation: _____

MEDICAL INSURANCE

Insurance Name: _____ Policy Type: _____

Insurance Phone Number: _____ Effective Date: _____

Insurance Address: _____ City/State/Zip _____

Patient Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Domestic Partner

Insured's Name: _____ Please fill out Insured Address Below if Different from Patient

Address: _____ City/State/Zip: _____

Social Security Number: _____ Insured Date of Birth: _____

Are You Covered Under Another Health Plan Policy Other Than the one Mentioned Above? ☐ Yes ☐ No

If Yes, Insurance Name: _____ Relationship To Insured: ☐ Self ☐ Spouse ☐ Child

Insured's Name: _____ Address: _____

Insured's Social Security Number: _____ Policy / Group Number: _____

Referring Physician: _____ Phone Number: _____

PHARMACY

Pharmacy Name: _____

Address: _____ City/State/Zip: _____

Pharmacy Phone Number: _____ Fax Number: _____

ASSIGNMENT AND RELEASE

I, The undersigned, have insurance coverage with _____ and assign directly to Dr. Pinkas E. Lebovits all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all changes whether or not paid by insurance. I hereby authorize the doctor to release information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature of the Insured/Guardian _____ Date: _____

MEDICARE

☐ Medicare _____ ☐ Medicaid _____

Effective Date: _____ ☐ Other Secondary: _____

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Pinkas E. Lebovits, M.D. for any services furnished me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co insurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature: _____ Date: _____