Dr. Shore Armani **Patient Registration** **(PLEASE PRINT CLEARLY!)**

Patient's Name: _____ SS #:_____
First Name MI Last name

Date of Birth: _____ __Male __Female __Single __Married __Widowed __Divorced __Separated

Street Address: _____

City/ State / Zip Code: _____ Home Phone w/Area Code: _____

Cell Phone w/ Area Code: _____ E-mail: _____

Spouse's Name: _____ SS #: _____

Spouse's Employer: _____ Spouse's Work Phone #:_____

Patient's Employer: _____ Work Phone w/Area Code: _____

Credit: (Circle) MC Visa #_____ Exp ___/___/___ Name on card _____

Responsible Party: _____ Relationship: __Self __Spouse __ Parent __Other:_____

If patient is a Minor, are parents __Married __Divorced Custodial Parent: _____

Custodial Parent's Home Phone w/Area Code:_____ Work Phone w/Area Code:_____
Custodial Parent's SS #: _____ Date of Birth: _____

In case of emergency, contact (not living with you): _____
Phone Number w/Area Code:_____ Relationship to Patient: _____

Is this work-related? __Yes __No If yes, date of injury? _____ Claim #:_____
How did this injury happen? _____
_____

Referring Physician's Name & Phone Number: _____

PLEASE PRESENT INSURANCE CARD(S) & PHOTO ID FOR COPYING AND COMPLETE THE REQUESTED INFORMATION

Insurance Company #1: _____ Phone Number: _____

>> Primary Insured's Name:_____ >>Date of Birth: _____
Policy #: _____ Group #: _____ Relationship: _____

Insurance Company #2: _____ Phone Number: _____

>> Primary Insured's Name:_____ >>Date of Birth: _____
Policy #: _____ Group #: _____ Relationship: _____

If you do not have insurance, have you applied for Medicaid? __Yes __No If yes, what is the name and phone number of the social worker with whom you are working? _____

I hereby authorize the payment of medical benefits to Doctor Armani for services rendered. I understand that I am financially responsible for any services not covered by my insurance carrier.
I further agree to pay all collections costs, attorney fees, and other collections costs that may be incurred to enforce the collection of any amounts outstanding.
I hereby authorize Dr. Armani to release any medical information necessary to complete and process my insurance claims.
For every bill received after the first bill, I agree to pay a $3 fine for any additional bill.
There will be a 3% fee for patients who would like to pay using Visa or MasterCard.

>>_____ _____
>> *Patient's OR Insured's Signature* (If patient is a Minor, must have Responsible Party Signature) Date

I authorize Dr. _____ to treat me and use my personal health information for healthcare operations.

>>_____ _____
Patient's Signature (OR Parent if patient is a Minor) Date