PATIENT REGISTRATION

Martha E. Stewart, M.D., L.L.C.

Please present your insurance card(s) and a driver's license to the receptionist along with this form. Please print • Shaded areas for office use

☐ **ADD** ☐ **CHANGE** Patient # _ _ _ _ _ _ _ _ _ _ _ _ Date____________________

PATIENT INFORMATION

Patient Name: Last First Middle Initial

Sex	Birthday	S.S. Number	Referring Doctor Name
☐ Male ☐ Female	_ _ / _ _ / _ _	_ _ _ - _ _ _ - _ _ _ _	

PATIENT / RESPONSIBLE PARTY INFORMATION

Guarantor Name: Last First Middle Initial

Patient Type:

Address:

City: State: Zip Code:

Home Phone: (_ _ _) _ _ _ - _ _ _ _ Work Phone: (_ _ _) _ _ _ - _ _ _ _ Ext: _ _ _ _

Cell Phone: (_ _ _) _ _ _ - _ _ _ _

PRIMARY INSURANCE

Insurance **Type**: ☐Medicare ☐Medicaid ☐Medigap ☐Workers Comp ☐Group ☐Individual ☐Commercial ☐Litigation ☐Supplement ☐Long Term ☐Auto ☐Other:

IC #: Carrier Name: Carrier Phone:

Carrier Address:

Subscriber Information: Last Name First Name Middle Initial

Sex (M/F): Birthday: SSN:

Mail claim to (check one): ☐ **I**nsurance Co. ☐ **E**mployer ☐ **P**atient

Employer: Empl. Phone:

Employer Address:

Ins. Policy #: Ins. Group #:

Patient's Relationship to Subscriber **(Circle One)**:

1 **Male patient** is subscriber
2 **Female patient** is subscriber
3 **Male spouse** of subscriber
4 **Female spouse** of subscriber
5 **Male Child** of subscriber
6 **Female Child** of subscriber
Other:

SECONDARY INSURANCE

Insurance **Type**: ☐Medicare ☐Medicaid ☐Medigap ☐Workers Comp ☐Group ☐Individual ☐Commercial ☐Litigation ☐Supplement ☐Long Term ☐Auto ☐Other:

IC #: Carrier Name: Carrier Phone:

Carrier Address:

Subscriber Information: Last Name First Name Middle Initial

Sex (M/F): Birthday: SSN:

Mail claim to (check one): ☐ **I**nsurance Co. ☐ **E**mployer ☐ **P**atient

Employer: Empl. Phone:

Employer Address:

Ins. Policy #: Ins. Group #:

Patient's Relationship to Subscriber **(Circle One)**:

1 **Male patient** is subscriber
2 **Female patient** is subscriber
3 **Male spouse** of subscriber
4 **Female spouse** of subscriber
5 **Male Child** of subscriber
6 **Female Child** of subscriber
Other:

HOW DID YOU HEAR ABOUT DR STEWART?

EMERGENCY INFORMATION

A friend or relative to contact in case of emergency (**NOT Responsible Party**)

Name:	Relationship:	Phone:
Address:	City, State, Zip:	

PLEASE SIGN BACK OF FORM ➜

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Martha E. Stewart, M.D., L.L.C., or any holder of medical information about me to release to the Health Care Financing Administration and its agents (Medicare) or Insurance Companies or Third Parties, any information needed to determine these benefits or the benefits payable for related services.

ASSIGNMENT OF BENEFITS

I request that authorized Medicare or Insurance payments of medical benefits be made to Martha E. Stewart, M.D., L.L.C. (to be used only if necessary to file claims).

GUARANTOR RESPONSIBILITY

I understand that I am ultimately responsible for payment of any and all charges for medical services rendered by Martha E. Stewart, M.D., L.L.C., and if this assignment is rejected, modified, or not paid within a reasonable time after it has been filed, it will be my responsibility to pay any unpaid charges in full. If it is necessary to collect unpaid fees for services rendered, I agree to pay the charge assessed by the collection service, legal counsel or court.

This authorization and assignment may be revoked by me at any time by a written notice.

I agree that a photocopy of this form may be used in lieu of the original.

________________________________ __________________

Signature of Insured/Patient Date

PERMISSION TO DISCUSS INFORMATION

Do you give our office permission to discuss your medical information (i.e. all health information, appointments, your medical condition, treatment, test results, prescriptions) with family members?

(Please initial one) Yes _______ No__________

If yes, please provide their name and phone number:

Name ________________________ Relationship________________ Phone____________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received the Notice of Privacy Practices, describing the privacy practices and safeguards as well as my rights with respect to my protected health information maintained and used by Martha E. Stewart, M.D., L.L.C..

________________________________ __________________

Signature of Insured/Patient Date