Shelley Berson, MD, FAASM, FAAOA Rockland Ear, Nose and Throat Associates, P.C.

PATIENT INFORMATION

Patient Last Name: ______________________________ Patient First Name: ______________________ Sex: M F

Home Address: ____

Date of Birth: ____________ Age: ______ Social Security Number (Patient): ____________________

Home Phone #: ____________ Cell Phone #: ____________ E-mail Address: ____________________

Work Phone #: ____________ Employer Name: ____

If Patient is UNDER 18 — Parent/Guardian Name: __________________________ Social Security # (Guardian): ____________

Parent/Guardian Phone #: ____________

REFERRING DOCTOR

Name: ______________________________

Address: ____

Office Phone #: ____________

PHARMACY

Pharmacy Name: ______________________________

Pharmacy Address: ____

Pharmacy Phone #: ____________ Pharmacy Fax #: ____________

EMERGENCY CONTACT

Name: ______________________________

Relationship To Patient: ______________________________

Contact Phone Home #: ____________ Contact Cell Home #: ____________ Contact Work Phone#: ____________

PRIMARY INSURANCE INFORMATION

Insurance Company Name: ______________________________

Phone #: ____________

Policy Holder Name: ______________________________ Policy ID #: ______________________

SECONDARY INSURANCE INFORMATION

Insurance Company Name: ______________________________

Phone #: ____________

Policy Holder Name: ______________________________ Policy ID #: ______________________

GUARANTOR INFORMATION

Subscriber Name (Policy Holder): ______________________________ Subscriber Social Security #: ____________

Address: ____

Date of Birth: ____________ Relationship to Patient: __________________________

Employer Name: ______________________________

I authorize any holder of medical or other information about me to release to the Social Security Administration and the Centers for Medicare and Medicaid Services or its intermediaries or carriers or to the billing agent of this physician , any information needed for this or a related Medicare claim. I permit a copy of his authorization to be used in place of the original, and request payment of insurance benefits either to myself or the party who accepts assignment.

Name ______________________ *Signature* __________________________ *Date* ____________

I authorize you to remit all medical benefits directly to Rockland Ear, Nose and Throat Associates, P.C.

Name ______________________ *Signature* __________________________ *Date* ____________