

STEPHEN J. CLARK M.D.,P.C. Patient Registration Form

Patient Name _____
(Legal) Last Name (Legal) First Name Middle

Address _____

City _____ State _____ Zip _____

Phone (cell) _____ (home) _____

Sex _____ Birthdate _____ SS# _____ Marital Status _____

**Emergency Contact Name _____ Phone _____

Responsible Party Name _____ Birth date _____

Address _____ City _____ State _____ Zip _____

Employer Name (resp. party) _____ Address _____

Phone (w) _____ Responsible Party SS# _____

Primary Insurance Carrier _____ HMO _____ PPO _____ POS _____ Other _____

ID# _____ Group/Plan # _____ Insured Name _____

Relationship to Insured: ___Self ___Spouse ___Child ___Other Insured DOB _____

Affiliation: () NSU-Highland Park Hospital () Northwestern Lake Forest Hospital

Secondary Insurance Carrier: _____ ID# _____

Group/Plan# _____ Insured Name _____ Insured DOB _____

Who referred you to our office? _____

Pharmacy Name _____ Pharmacy # _____

Assignment & Release

I assign directly to Drs. Clark/Kharasch all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorized the doctor to release all medical information necessary to secure the payment on all my insurance submissions. I am responsible for all non sufficient fund checks returned with an additional \$35 fee.

Signature of Insured/Guardian Today's Date

Medicare Authorization

I request that payment of Medicare benefits be made on my behalf to Drs. Clark/ Kharasch for any services furnished by that physician. I authorize any holder medical information about me to release to the Health Care Financing Administration & its agents any information needed to determine these benefits payable. 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 on the HCFA-1500 form submitted manual or electronic, my signature authorized release of information to the insurer or agency shown. I understand I am responsible for deductible, coinsurance and noncovered services.

Beneficiary Signature Today's Date

THIS FORM WILL EXPIRE 1 YEAR FROM TODAY'S DATE, NEW FORMS WILL NEED TO BE COMPLETED.