PRECISION ASPIRATION and BIOPSY
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REGISTRATION
(PLEASE PRINT)

Date _____ **Home Phone**_____
Patient _____
Last Name **First Name** **Initial**
Responsible party (if a minor)_____
Street Address_____
City_____ **State**_____ **Zip** _____
Gender □ Male □ Female □ Single □ Married □ Widowed □ Separated □ Divorced
Age _____ **Birthdate** _____
Patient Social Security No. _____
Patient Employed by_____
Business address _____
Occupation _____ **Business phone** _____
Other phone (i.e. cell phone) where you may be reached _____
Spouse (or responsible party) Name _____ **Birthdate** _____
Patient Employed by_____
Business Name and Address_____
Occupation _____ **Business phone** _____
Who is responsible for this account?_____**Relationship to Patient**_____
Nearest relative not living with you _____ **Phone** _____
In case of Emergency, who should be notified?_____ **Phone** _____
Referred By _____ **Phone** _____
Primary Physician _____ **Phone** _____
Primary Insurance Company _____
Insured Name _____ **Date of Birth** _____
Social Security No._____
Group or Policy No._____ **Subscriber No.** _____
Secondary Insurance Company _____
Insured Name _____ **Date of Birth** _____
Social Security No._____
Group or Policy No._____ **Subscriber No.** _____

ASSIGNMENT OF BENEFITS AND RELEASE
I, the undersigned, have insurance coverage with _____
Name of Insurance Company
and I assign payment of authorized Medicare benefits and any other medical and/or surgical benefits to which I am entitled, directly to Precision Aspiration and Biopsy, for any services furnished me by the physician, Dr. Nadelman. I understand that I am financially responsible for all charges, whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ **Date** _____
Name of Insured/Guardian