



Celina M. Nadelman, M.D.

Fine Needle Aspiration Specialist

Fast, Accurate, Compassionate: A Superior Way to Biopsy

Celina Nadelman, M.D. Laboratory Director

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REGISTRATION FORM

(PLEASE PRINT)

PATIENT INFORMATION

Name _____ Social Security No. _____
Last First Middle Initial

Date of Birth ____/____/____ Sex (circle one) Male / Female

RESPONSIBLE PARTY

(If you are under the age of 18, place parent's info here)

Home Address _____

City _____ State _____ Zip _____

Home Phone _____ Business Phone _____ Cell Phone _____

Employer/Occupation _____

INSURANCE INFORMATION

Primary Insurance Company _____ Policy ID _____

Group NO. _____

Policy Holder's Name _____ DOB ____/____/____ Sex _____

Secondary Insurance Company _____ Policy ID _____

Group NO. _____

Policy Holder's Name _____ DOB ____/____/____ Sex _____

Referred By _____ Phone _____ Fax _____

EMERGENCY CONTACT INFORMATION

Emergency Contact Name _____ Phone _____

Relationship to Patient _____

Nearest Relative Not Residing With You _____ Phone _____

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.

Name of Insured/Guardian Date _____