Ronald M. Friedman, M.D., P.A.

Cosmetic and Reconstructive Plastic Surgery · Hand Surgery and Microsurgery

BOARD CERTIFIED, AMERICAN BOARD OF PLASTIC SURGERY

New Patient Registration

Patient Name ______________________________ Date of Birth ____/____/____
(Last) (First) (M.I.)

Home Address ______________________________
(Street) (City) (State) (Zip)

Phone # ( ) __________ Cell # ( ) __________ Work # ( ) __________

E-Mail __________ Beeper # ( ) __________ Fax # ( ) __________

SSN #__________ Male / Female Marital Status ______ Student Status Yes / No Full Time / Part Time

Employer __________ Title __________ Phone ( ) __________
(Patient)

Address ______________________________
(Street) (City) (State) (Zip)

Person to Notify in Case of Emergency __________ Relationship______ Phone ( ) __________

Primary Insurance Co. __________ Member # __________ Group #__________

Address__________ Benefit Phone ( ) __________ Pre-Cert Phone ( ) __________

Name of Insured __________ SSN #__________ DOB of Insured __________

If the Patient is a minor, the following information must be completed!

Parent or Legal Guardian __________ Relationship __________ SSN#__________

Address______________________________
(Street) (City) (State) (Zip)

Phone ( ) __________ Driver's License # __________ State ______ Exp ______

Employment __________ Title __________ Phone ( ) __________

Address ______________________________

Address of Insured (If different from above) __________ Date of Birth __________

Do you (patient) have any other health insurance? Yes / No (circle one)

Our Office does not file for Secondary Insurance. Please ask if you need a statement to file.

I hereby authorize **Ronald M. Friedman, M.D., P.A.** to furnish information to my insurance carrier concerning my illness and treatments, and I hereby assign to Dr. Friedman all payments for medical services rendered to myself or my dependents (unless Dr. Friedman has declined to accept assignment). I understand that I am responsible for any amount not covered by insurance. I understand that an explanation of benefits mailed to me by my insurer shall be considered notification of my responsibility to pay for the provided services. (A copy of this authorization shall be valid as the original.)
I understand and agree that regardless of my insurance status, I am ultimately responsible for my account balance for any professional services rendered.
I certify that the information on this form is true and correct to the best of my knowledge. I will notify your office of any changes.

Signature ______________________________ Date __________

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