Patient: This Section Refers to the Patient Only

Last Name	First Name	M.I	Address: Street and Number, Apt #, Box #
City	State	Zip Code	Home Telephone No. ( ) / Work Telephone No. ( )
Social Security No.		Date of Birth / Age	Cellular Telephone No. ( )
Employer Name		Employer Address: Street and Number, Box #	
City	State	Zip	Type of Business
Marital Status	Sex: Male Female	Source of Referral: Please Circle whether patient or physician Name:	
Spouse/Guardian		Address: Street and Number, Box #	Apt. #
City	State	Zip	Home Telephone No. ( ) / Work Telephone No. ( )
Spouse's Social Security No.		Spouse Date of Birth / Age	Work Telephone No. ( )
Spouse's Employer		Employers Address	
City	State	Zip	Type of Business
Emergency Contact Name	Emergency Contact #	Relationship	

Billing: Please complete if person responsible for bill is other than above patient.

Last Name	First Name	M.I	Address: Street and Number, Apt, # Box #
City	State	Zip Code	Home Telephone No. ( ) / Work Telephone No. ( )
Social Security No.	Relationship to Patient	Date of Birth	Sex: Male Female
Employer Name		Employer Address: Street and Number, Box #	
City	State	Zip Code	Type of Business

INSURANCE INFORMATION: Please give us all pertinent information regarding your insurance coverage. If you have coverage by more than one carriers, Supply information of both carriers. Please list all numbers on your card(s). Please check your insurance policy for waiting periods before coverage or pre-existing clauses. IF YOUR COVERAGE IS CONTINGENT ON A SECOND OPINION OR PRE-AUTHORIZATION APPROVAL, PLEASE BE SURE TO TELL US.

PRIMARY Insurance Plan	Policy No.			Group No.
Co-Pay Amount ($)	Effective Date			Termination Date
Subscriber Name	Patient Relationship to Subscriber			
Insurance Company Address	City	State	Zip Code	Insurance Co. Telephone No.

PRIMARY Insurance Plan	Policy No.			Group No.
Co-Pay Amount ($)	Effective Date			Termination Date
Subscriber Name	Patient Relationship to Subscriber			
Insurance Company Address	City	State	Zip Code	Insurance Co. Telephone No.

To my Insurance Carrier(s): * I authorize the release of any medical information necessary to process claims to P.R.S Inc. *I authorize and request payment of medical benefits directly to Maryellen Romano, M.D. * I agree that his authorization will cover all medical services until such authorization is revoked by me. * I agree that a photocopy of this form may be used in lieu of the original. * I agree to pay all charges not covered by insurance carrier(s). These charges include but are not limited to deductibles and co-payments of my insurance policy.

Signature____ Date:_____________________________________

Patient Registration Form