Jerome Naifeh, M.D.

Registration Form

Incomplete demographics can result in claim delays/denial, forcing responsibility onto the patient/responsible party. Please fill form out completely.

Today's Date _____/_____/_____ Drivers License#_____

PERSONAL INFORMATION

Last Name	First	Middle	❑ Mr. ❑ Miss. ❑ Mrs. ❑ Ms.	Marital Status (Circle One) Single / Mar / Div / Wid / Other

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former Name)	Birth Date / /	Age	Sex ❑ M ❑ F

Address	City	State	Zip

SSN#	Home Phone No. ( )	Alternate Phone No. ( )	How did you hear about us?

Occupation	Employer	Employer Phone No. ( )

Employer Address	City	State	Zip code

Other Family Members Seen Here:	Email address:

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship	Home Phone No. ( )	Work Phone No. ( )

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Person Responsible for Bill:	Birth Date / /	Address (if different)	Sex ❑ Male ❑ Female
Have you been treated by our office before? ❑ Yes ❑ No			Home Phone No ( ).

Occupation	Employer	Employer Address	Employer Phone No. ( )

Are you covered by insurance? ❑ Yes ❑ No	Effective Date of coverage (If known):

Primary Insurance Carrier Name:	Claim filing address (If unknown, leave blank):

Policy Holder's Name	Policy Holder's SSN#	Birth Date / /	Group #	Policy #	Co-Payment $

Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other _____

Secondary Insurance (if applicable)	Policy Holder's Name	Group #	Policy #

Policy Holder's SSN#	Policy Holder's DOB	Relationship to Policy Holder ❑ Self ❑ Spouse ❑ Other

The above information is true to the best of my knowledge. I understand that I am financially responsible for any balance. I also authorize Jerome G. Naifeh, M.D. to release any information required to process my claims.

X _____

SIGNATURE DATE