Patient Registration Information

Please PRINT and COMPLETE ALL sections below!

Patient's Personal Information Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed **Sex:** ☐ Male ☐ Female

Name: _____ _____ _____
Last First Initial

Date of Birth: _____ / _____ / _____ Social Security: _____ - _____ - _____

Home Phone: (_____) _____ Work Phone: (_____) _____ Cell Phone: (_____) _____

Address: _____ Apt #: _____ City: _____ State: _____ Zip: _____

Patient's/ Responsible Party Information Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Name: _____ _____ _____
Last First Initial

Date of Birth: _____ Social Security: _____ - _____ - _____ Driver License #: _____

Home Phone: (_____) _____ Work Phone: (_____) _____ Cell Phone: (_____) _____

Address: _____ Apt #: _____ City: _____ State: _____ Zip: _____

Patient's Insurance Information Please present insurance card and driver's license to receptionist.

Primary Insurance Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Name of Subscriber: _____ Date of Birth: _____ Relationship to Insured
☐ Self ☐ Spouse
☐ Child ☐ Other

Policy #: _____ Group #: _____

Employer Name: _____ Copay: _____

Secondary Insurance Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Name of Insured: _____ Date of birth: _____ Relationship to Insured
☐ Self ☐ Spouse
☐ Child ☐ Other

Policy #: _____ Group #: _____

Employer Name: _____ Copay: _____

Patient's PCP/Pediatrician Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Referring Physician (if not the same as PCP/Pediatrician) Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Assignment of Benefits – Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly to ERIC STELNICKI MD PA, and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collections, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Date: _____ Patient or Guardian Signature: _____