CARL L. FALCONE, MD / PATIENT REGISTRATION FORM

PATIENT INFORMATION (please print clearly)

Referred by MD: _____ Phone#: _____

Primary Physician: _____ Clinic: _____

Patient Last Name _____ First _____ Middle Initial _____ DOB _____

SS# _____ Male ☐ Female ☐ Married ☐ Divorced ☐ Widowed ☐

Address _____ City/ State _____ Zip _____

Home Phone# _____ Cell# _____ Alternate# _____

Patient Employer _____ Work# _____

Emergency Contact _____ Relationship _____ Phone# _____

RESPONSIBLE PARTY (person signing this form authorizing treatment if other than patient)

Last Name: _____ First _____ Middle Initial _____ DOB _____

SS# _____ Home# _____ Cell# _____

Address (if different from above) _____

City/State _____ Zip _____

Relationship to patient _____ Employer _____ Work# _____

HEALTH INSURANCE INFORMATION (present current insurance cards to receptionist)

Primary Insurance Co./ _____ ID# _____ Group# _____

Policy Holder's Name _____ DOB _____ Relationship to Patient _____

Policy Holder's SS# _____ Employer _____ Work# _____

Secondary Insurance Co _____ ID# _____ Group# _____

Policy Holder's Name _____ DOB _____ Relationship to Patient _____

Policy Holder's SS# _____ Employer _____ Work# _____

Note: Is today's visit related to work/auto injury? Yes ☐ No ☐

Records Release: I hereby authorize the release of any information by Carl L. Falcone MD to my referring doctor, insurance company and immediate family on behalf of myself and or dependents.

Initials _____

Assignment of Benefits: I hereby authorize payment of benefits to Carl L Falcone, MD PC for any services rendered to me and/or dependents.

Initials _____

Medicare Authorization: (Medicare Only) I request that payment of authorized Medicare benefits be made to me or on my behalf to Carl L Falcone, MD, PC for any services furnished by that clinic. I authorize any holder of hospital or medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of the authorization to be used in place of the original.

Initials _____

I acknowledge that if my health insurance plan requires a referral, it is my responsibility to obtain the necessary referral. I further acknowledge that whether my insurance plan requires a referral or not, I am ultimately responsible for the financial charges (18%) that I incur with Carl L Falcone, MD, PC. A copy of this authorization will be treated in the same manner as an original.

Date: _____ ***Signature of Responsible Party*** _____