Rachel B. Rubin-Toles, MD
PATIENT REGISTRATION

Patient Name (Last): _____ **First:** _____ **Init:** _____

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

Home Phone: _____ Work Phone: _____ **DOB:** _____

Patient Social Security #: _____ Male__ Female__ Marital Status: M__ S__ D__ W__

Patient Employer: _____ Address: _____

Occupation: _____ Work Status: _____ Student Status: _____

Primary Care Physician: _____

Responsible Party Name: _____ Relationship to Patient: _____

Responsible Party Social Security #: _____ DOB: _____

How will the bill be paid today? _____

EMERGENCY CONTACT: _____ **PHONE #:** _____

Primary Insurance Company: _____

Policy Holder Name: _____ Policy Holder Date of Birth: _____

Relationship to Patient: _____ Employer: _____

Policy Number: _____ Group Number: _____

Co-pay: _____ Deductible: _____

Effective Date of Coverage: _____

Secondary Insurance Company: _____

Policy Holder Name: _____ Policy Holder Date of Birth: _____

Relationship to Patient: _____ Employer: _____

Policy Number: _____ Group Number: _____

Effective Date of Coverage: _____

Where did you hear about Dr. Rubin-Toles? _____

Do you have a living will? YES NO Would you like information on a living will? YES NO

I certify that information provided pertaining to my health insurance coverage is true and correct. I authorize that payment for services rendered should be made payable to Rachel B. Rubin-Toles, M.D. I authorize release of medical information necessary to process this (these) claim(s). I have read all the terms and conditions contained in this agreement and agree to be bound by these terms and conditions.

Signature: _____ Date: _____