NIKI SILVERSTEIN, MD

PATIENT REGISTRATION (PLEASE PRINT CLEARLY)

Date: _____

PATIENT INFORMATION:

Last Name_____ **First Name** _____**Middle**____
Address_____**City**_____**State**_____**Zip** _____
Home# ( ) _____ **Work#** ( ) _____ **Cell #** ( )_____
Date of Birth _____**Age** _____ **Sex: M / F Social Security#**_____
Marital Status_____**Employer/School**_____**Occupation** _____
Primary Doctor/address/ phone#_____
Who referred you to our office? _____ **Referring Doctor** _____
Please tell us how you found out about our office. Please check off all that apply.

Found us on the Internet_____Visited our website_____ Saw ad in Observer Tribune_____Saw ad in NJ Monthly_____
Saw ad in Warren Reporter_____Saw article about us in a newspaper_____ Saw us on Patch_____
Saw us somewhere else. Where? _____
Do you have any family members who are patients of our office? Names and relation _____
_____ **E-mail address:** _____
Pharmacy name/address/phone#_____

PRIMARY INSURANCE

Insurance Name_____ID#_____Group#_____
Insurance Address_____City_____State_____Zip_____
Referrals Required? Y / N Subscriber Name_____Relation to Patient_____
Subscriber Date of Birth_____Social Security#_____Employer_____

SECONDARY INSURANCE

Insurance Name_____ID#_____Group#_____
Insurance Address_____City_____State_____Zip_____
Referrals Required? Y / N Subscriber Name_____Relation to Patient_____
Subscriber Date of Birth_____Social Security#_____Employer_____

TERTIARY INSURANCE

Insurance Name_____ID#_____Group#_____
Insurance Address_____City_____State_____Zip_____
Referrals Required? Y / N Subscriber Name_____Relation to Patient_____
Subscriber Date of Birth_____Social Security#_____Employer_____

FINANCIAL DISCLAIMER

INITIAL HERE_____ACCOUNT RELEASE: I hereby agree to be responsible for all purchases made on this account. The account will be paid in accordance with the following terms: A collection fee representing one-third of the outstanding balance will be added if the account is referred to an outside company of attorney. I authorize the release of any medical information necessary for treatment, for consideration of services rendered. I agree to pay all debts incurred. Further I authorize the release of medical benefits to my physician.
INITIAL HERE_____HIPPA RELEASE: The major goal of HIPPA (Health Insurance Portability & Accountability Act of 1996) is to assure that individuals' health information is properly protected while allowing the flow of health information needed to provide and promote high quality healthcare and to protect the public's health and well being. We are required by law to maintain the privacy of your health information. This notice is effective as of April 14, 2003. By signing this document you acknowledge receipt of Niki Silverstein Eye MD, LLC's Notice of Privacy Practices.

Patient's Signature_____ **Date**_____
Responsible party for this Patient's Account?_____ **Relation to patient** _____