

Dr. Paula Nadell Patient Registration

Date _____

 Last Name First Middle Social Security # Date of birth Age

 Address City State Zip Code Home Phone # Message or Cell #
 May we leave a message with your home #? Yes No
 May we leave a message with your work #? Yes No

 Employer Occupation

 Employer Address Work Phone #

 Marital Status PCP Name Phone # Referred by

 Spouse's Name (or Parent or Guardian if Patient is under 18) Social Security # Date of Birth

 Spouse's Employer & work address Work Phone # Occupation

 Closest relative to you, not living with you: Name, Address, Phone number and Relationship

Medical Insurance Information:

 Insurance Company Name Insured Person's Name Relationship Date of Birth

 Insurance Claims Address City State Zip Code Phone #

 ID/Policy # Group # Group Name

2nd Insurance Company Name Insured Person's Name Relationship Date of Birth

 Insurance Claims Address City State Zip Code Phone #

 ID/Policy # Group # Group Name

In an effort to control billing expenses, our office policy requires payment of the co-pay or any applicable fees prior to your being seen by the physician, unless you present in an emergency. Waivers are on file for Non-Covered services.

Insurance assignment: I authorize my insurance benefits to be paid directly to the Physician. I understand that I am financially responsible for charges denied as "NON-COVERED" by my insurance carrier. I also authorize Dr. Nadell to release any information required for the insurance company to process my claims.

 Patient Signature (or Parent /Guardian if Patient is a minor) Date