Larry Kaufman MD, LLC
Women's Medical Specialty

PATIENT REGISTRATION FORM

Patient Name _____ SS# _____ DOB _____

(If Minor) Parent's Names _____ ***E-mail address** _____

Address _____ City _____ State_____ Zip _____

Home Phone (_____) _____ Work (_____) _____ ext. _____ Cell (_____) _____

Circle one: S M D W Sep Occupation _____

Employer _____ Business Address _____

Spouse's Name _____ SS# _____ DOB _____

Spouse's Employer _____ Business Address _____

Spouse's Occupation _____ Work Phone (_____) _____ ext. _____

PRIMARY INSURANCE _____

Insured's Name _____ SS# _____ DOB _____

Group # _____ ID# _____

SECONDARY INSURANCE _____

Insured's Name _____ SS# _____ DOB _____

Group # _____ ID# _____

How did you learn about our practice? _____

Emergency Contact _____ Phone (_____) _____ Relationship _____

ALLERGIES: _____ Pharmacy _____ Phone (_____) _____

Larry J Kaufman MD, LLC will submit a claim to my insurance carrier for services rendered me and will receive payment according to their contractual agreement. I will be financially responsible for any co-pay, co-insurance, or non-covered services. The insurance information I am providing is true, accurate, and currently in effect. *By providing my e-mail address, I authorize the practice to send me results of medical reports and practice related information.

Signature _____ Date _____