

**WELCOME TO OUR OFFICE**  
**BENNETT S. ROMANOFF, M.D., INC.**

Please PRINT and complete ALL sections below

**PERSONAL INFORMATION (Please Print)**

Name \_\_\_\_\_ Date \_\_\_\_\_

How do you wish to be addressed? \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

M/F \_\_\_\_\_ Social Security # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

E-Mail Address \_\_\_\_\_

Zip \_\_\_\_\_ Home Phone (\_\_\_\_\_) \_\_\_\_\_

Occupation \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

Marital Status  Single  Married  Divorced  Widowed

Spouse's Name \_\_\_\_\_ Employer \_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION, IF OTHER THAN PATIENT**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Relationship to Patient  Self  Spouse  Other \_\_\_\_\_

Responsible Party's Address \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_

Employer \_\_\_\_\_ Phone Number (\_\_\_\_\_) \_\_\_\_\_

**REFERRAL INFORMATION**

Physician  Yellow Pages  Referred by other \_\_\_\_\_

Friend/Relative-Name \_\_\_\_\_

Name of Primary Care Physician \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number(\_\_\_\_\_) \_\_\_\_\_

**EMERGENCY CONTACT**

Name of person not living with you \_\_\_\_\_

Relationship \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_

**INSURANCE INFORMATION (Please present insurance cards to receptionist)**

**Please give all pertinent information regarding your insurance coverage. If you have coverage by more than one carrier, supply information on all carriers.**

IF YOUR COVERAGE IS CONTINGENT ON A SECOND OPINION OR PREADMISSION APPROVAL, IT IS YOUR RESPONSIBILITY TO SUPPLY ALL FORMS AND OBTAIN APPROVAL FROM YOUR INSURANCE COMPANY.

**PRIMARY INSURANCE** \_\_\_\_\_

POLICY HOLDER'S NAME \_\_\_\_\_

ID# \_\_\_\_\_ GROUP# \_\_\_\_\_

POLICY HOLDERS SS# \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

**SECONDARY INSURANCE** \_\_\_\_\_

POLICY HOLDER'S NAME \_\_\_\_\_

ID# \_\_\_\_\_ GROUP# \_\_\_\_\_

POLICY HOLDER'S SS# \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

**THIRD INSURANCE** \_\_\_\_\_

POLICY HOLDERS NAME \_\_\_\_\_ GROUP# \_\_\_\_\_

POLICY HOLDER'S SS# \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

**VISION INSURANCE** \_\_\_\_\_

POLICY HOLDER'S NAME \_\_\_\_\_

ID# \_\_\_\_\_ GROUP# \_\_\_\_\_

POLICY HOLDER'S SS# \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

**FINANCIAL ASSIGNMENT AND AGREEMENT**

1. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the physician and is not substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance company at the conclusion of each visit.
2. I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished me. I authorized any holder of medical information about me to release to the Health Care Financing Administration, its agents, or any insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services.
3. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges, whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.
4. I hereby authorize Dr. Bennett Romanoff to treat myself or my dependent.

**Signature X** (Patient or Parent if minor)

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