WELCOME TO OUR OFFICE
Bennett S Romanoff MD, INC.

Please PRINT and complete ALL sections below

Name:_____Date_____

How do you wish to be addressed?_____Date of Birth_____Age_____

M/F_____Social Security #_____Email Address_____

Address_____City_____State_____

Zip Code_____Primary Phone# ( )_____Secondary Phone( )_____

Marital Status □ Single □ Married □ Divorced □ Widowed

Spouse's Name_____ Pharmacy Name and Phone_____

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT:

Name_____Social Security#_____Date of Birth_____

Address_____City_____State_____Zip Code_____

Primary Phone ( )_____ Employer_____

Relationship to Patient □ Self □ Parent □ Guardian

REFERRAL INFORMATION:

□ Physician □ Google □ Internet □ Newspaper/Magazine □ Friend/Relative- Name_____

□ Other_____

Name of Primary Care Physician_____Phone ( )_____

Address_____City_____State_____ZipCode_____

HIPAA APPROVED CONTACTS:

Name_____Phone ( )_____

Address_____City_____State_____ZipCode_____

Name_____Phone ( )_____

Address_____City_____State_____ZipCode_____

Please complete other side

VISION INSURANCE:

Name_____ID#_____Policy Holder's Social Security_____

Policy Holder's Name_____Date Of Birth_____

MEDICAL INSURANCE:

Primary Insurance_____ID#_____Group#_____

Policy Holder's Name_____Social Security#_____

Date of Birth_____Employer_____

Secondary Insurance_____ID#_____Group#_____

Policy Holder's Name_____Social Security#_____

Date of Birth_____Employer_____

I hereby authorize Dr. Bennett Romanoff to treat myself or dependent. I request that payment of authorized Medicare an/or other insurance benefits be made to Bennett S Romanoff MD, INC on my behalf for any services furnished to me. I authorized any holder of medical information about me to release to CMS, it's agents, or any other insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services. I further understand that I am responsible for all co-pays, co-insurance, deductible and non-covered services that my insurance carrier does not cover. Known Co-pays are due at the time of service, or a fee may be incurred. There is a $40.00 service charge on all returned checks. Appointments missed without 24 hour notice will be subject to a $45.00 charge. There will be a 30% collection fee for all accounts turned over to an outside agency in attempt to collect monies due this office. I acknowledge receipt of Bennett S. Romanoff MD INC Notice of Privacy Practices. I authorize the use and disclosure of my health information for purposes of treating me, obtaining payment for services rendered to me and conducting healthcare operations.

Responsible Party Signature **Date**

I have reviewed all of the above information. My information has changed as follows (if there are no changes check the NO CHANGES area

Date_____Signature_____ No Changes □

Changes_____

Date_____Signature_____ No Changes □

Changes_____

Date_____Signature_____ No Changes □

Changes_____

Date_____Signature_____ No Changes □

Changes_____

Date_____Signature_____ No Changes □

Changes_____