# Susan Lurie M.D

## REGISTRATION FORM

(Please Print)

| | | | | | |
|---|---|---|---|---|---|
| Today's Date: | | | | PCP: | |

### PATIENT INFORMATION

| | | | | | |
|---|---|---|---|---|---|
| Patient's Last Name: | First: | Middle: | ❑ Mr. ❑ Mrs. | ❑ Miss ❑ Ms. | Marital Status (circle or<br>Single / Mar / Div / |

| | | | | | |
|---|---|---|---|---|---|
| Is this your legal name?<br>❑ Yes ❑ No | If not, what is your legal name? | Social Security No: | Date of Birth:<br>/ / | Age: | Sex<br>❑ M |

| | | |
|---|---|---|
| Street Address: | Home Telephone No:<br>( ) | Cellphone No:<br>( ) |

| | | | |
|---|---|---|---|
| P.O. Box: | City: | State: | ZIP Code: |

| | | |
|---|---|---|
| Occupation: | Employer: | Employer Telephone No:<br>( ) |

| | | |
|---|---|---|
| Referred to clinic by: | Ethnicity: | Race: |

Other family members seen here:

### INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

| | | | |
|---|---|---|---|
| Person responsible for bill: | Date of Birth:<br>/ / | Address (if different): | Home Telephone No:<br>( ) |

Is this person a patient here? ❑ Yes ❑ No

| | | | |
|---|---|---|---|
| Occupation: | Employer: | Employer Address: | Employer Telephone No:<br>( ) |

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate Primary Insurance

| | | | | | |
|---|---|---|---|---|---|
| Subscriber's Name: | Subscriber's S.S. No: | Date of Birth:<br>/ / | Group No: | Policy No: | C<br>$ |

| | | | | | |
|---|---|---|---|---|---|
| Patient's relationship to subscriber: | ❑ Self | ❑ Spouse | ❑ Child | ❑ Other | |
| Name of Secondary Insurance (if applicable): | Subscriber's Name: | | Group No: | Policy N | |
| Patient's relationship to subscriber: | ❑ Self | ❑ Spouse | ❑ Child | ❑ Other | |

| IN CASE OF EMERGENCY | | | |
|---|---|---|---|
| Name of local friend or relative (not living at same address): | Relationship to patient: | Home Telephone No:<br>( ) | Work Tele<br>( ) |

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand th financially responsible for any balance. I also authorize Susan Lurie M.D or insurance company to release any information required to process n

Patient/Guardian Signature

Date