# REGISTRATION
(PLEASE PRINT)

**RONALD G. FRANK, M.D**
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| | | | |
|---|---|---|---|
| Date | Home Phone | Account # | Form # |
| Patient Last Name | First Name | | Initial |
| Responsible Party (if a minor) | | | |
| Street Address | | | |
| City | State | | Zip |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Sex M ☐ F ☐ | Age | Birthdate | Single | Married | Widowed | Separated | Divorced |

| | | |
|---|---|---|
| Patient Employed By | | |
| Business Address | | |
| Occupation | Business Phone | |
| Spouse (or responsible party) Name | Birthdate | |
| Business Name and Address | | |
| Occupation | Business Phone | |
| Who is responsible for this account? | Relationship to Patient | |
| Patient's Social Security number | Spouse's Social Security # | |
| Did you have Medical Insurance? No ☐ Yes ☐ >>> If yes, | | |
| Name of Primary Insurer | | |
| Group number | Subscriber number | Contact number |
| Name of Secondary Insurer (if any) | | |
| Group Number | Subscriber number | Contact number |
| Medicare | Medicaid | Claim ID # |
| E-Mail Address | Cell Phone | |
| In case of emergency who should be notified? | Phone | |
| How did you learn of our practice? | | |

## ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____
Name of Insurance Company

and assign directly to Dr.Frank all medical benefits unpaid by me.I understand that I am financially responsible for all charges not paid by insurance. I hereby authorize Dr. Frank to release all information necessary and my signature to secure the payments of benefits.

X_____
Signature of Insured/Guardian Date

**MEDICARE AUTHORIZATION**

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. _____ for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If ''other health insurance'' is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge demination of the Medicare Carrier.