

MAGA Medical Care PC

DR. MARK GALPERIN

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REGISTRATION

(PLEASE PRINT)

Date _____ Home Phone (____) _____ Cell Phone (____) _____

PATIENT INFORMATION

Name _____ SS/HIC/Patient ID # _____
Last Name First Name Middle Initial
 Address _____ E-mail _____
 City _____ State _____ Zip _____
 Sex M F Age _____ Birthdate _____ Married Widowed Single Minor
 Separated Divorced Partnered for _____ years
 Patient Employer/School _____ Occupation _____
 Employer/School Address _____ Employer/School Phone (____) _____
 Whom may we thank for referring you? _____
 In case of emergency who should be notified? _____ Phone (____) _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Middle Initial
 Relation to Patient _____ Birthdate _____ Soc. Sec. # _____
 Address (If different from patient's) _____ Phone (____) _____
 City _____ State _____ Zip _____
 Person Responsible Employed by _____ Occupation _____
 Business Address _____ Business Phone (____) _____
 Insurance Company _____
 Contract # _____ Group # _____ Subscriber # _____
 Names of other dependents covered under this plan _____

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information relating to all claims or benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits for services rendered or for services to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim, I hereby authorize my insurance carrier to pay and hereby assign directly to _____ all benefits, if any, otherwise payable to me for her/his services as described on the claim forms. Understand I am financially responsible for all charges incurred. I further acknowledge that my insurance benefits, when received by me and paid to _____ will be credited to my account, in accordance with the above said assignment, I hereby agree and understand that if I receive payment from my insurance company for services rendered by _____, I am to endorse the check and mail with statement to her/his office. I clearly understand that it is still my responsibility to make sure the bill is paid in a reasonable time. If for any reason any portion of my bill is not paid by my insurance, I further agree to make arrangements for prompt payment of the bill, I acknowledge and understand the fact that if for some reason I fail to submit payment on my account and my account is being reported to a collection agency, collection fee of 20% of the balance will be added to my account.

PATIENT'S SIGNATURE _____ DATE ____/____/____