PATIENT REGISTRATION - Please Print Clearly

PATIENT NAME ___________________________________ HOME PHONE ______________
Last First Middle

Patient Address ____
Street City State Zip

Alternate Contact Information: Cell: ________________ Email: ________________________

Patient Date of Birth ________________ Age ________ Sex: Male _______ Female ________

Social Security # _______________________________ Occupation _____________________

Employer ____________________________________ Business Phone _________________

Name of Spouse _______________________________ Occupation _____________________

Referring Doctor _______________________________ Phone ________________________

Primary Doctor _________________________________ Phone ________________________

Insurance Information

- **PRIMARY INSURANCE** ____

Subscriber Name ______________________________ Self____ Spouse ____ Parent ______

Subscriber Birthdate ____________ Member SSN _____________ Group # _______________

- **SECONDARY INSURANCE** ____

Subscriber Name ______________________________ Self____ Spouse ____ Parent ______

Subscriber Birthdate ____________ Member SSN _____________ Group # _______________

In case of emergency, local friend or relative to be notified:

Name____ Phone ______________________

Relationship to patient ____

I understand that my insurance(s) will be filed, as a courtesy, but I remain solely responsible to Robert J.Cornell, M.D. for all charges incurred. I hereby authorize Robert J.Cornell, M.D. and/or it's representative to release any and all information necessary to process my insurance claim(s). I hereby authorize my insurance company(s) to pay benefits directly to Robert J.Cornell, M.D. I hereby authorize Robert J.Cornell, M.D. to release my medical records to other physicians who may also provide medical care to me.

Signature _______________________________________ **Date** ________________________