ALEXANDRA PELLICENA, MD, PA PATIENT REGISTRATION FORM

_____ _____ _____

Last Name (Please Print) **First Name** (Please Print) **Middle Name**

Date of Birth: __ __-__ __-__ __ __ __ **Social Security:** __ __ __-__ __- __ __ __ __

Month Day Year

TELEPHONE: Home__ __ __-__ __ __-__ __ __ __ **Work**__ __ __-__ __ __-__ __ __ __ _____

Email address:_____ **Ext.**

_____ _____ _____, _____, _____

Address (Street number and name) APT # City State Zip

Marital Status: (Circle one) S M D W Sep If married, **Husband's Name**_____

Home Town (Birthplace)_____ **Ethnic Origin**_____

Referred by: _____

Emergency Contact: _____**Phone:** _ _ _ - _ _ _ - _ _ _ _

Religious Preference: _____ **Occupation:** _____

Employer: _____

PRIMARY INSURED PERSON'S INFORMATION

_____ _____ _____

(Last Name) (First Name) (Middle Name)

Insured's Relationship To Patient: **SELF SPOUSE PARENT OTHER** _____

Name of Insured's Employer: _____

Insured's Date of Birth__ __-__ __-__ __ __ __ **Work Phone** _____ -_____-_____

Social Security Number ___ ___ ___ - ___ ___ - ___ ___ ___ ___

INSURANCE COMPANY INFORMATION

NAME OF INSURANCE COMPANY_____

(Circle One) HMO PPO POS EPO Other ___ **Group or Plan#**_____

ID/SS No. (or Member or Cert Number)_____

Member Service/Customer Service Phone Number _____-_____-_____

Mail Claims to: _____

_____

_____

If HMO/POS, give Primary Care Physician's name and name of his/her network.

_____

Primary Care Physician's Phone Number __ __ __ -__ __ __ -__ __ __ ___

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If patient is a **minor,** or is **mentally impaired,** please complete the following:

Parent/Guardian_____**Relationship**_____

Phone Number____-_____-_____ **Address:** _____

City_____**State**_____ **Zip Code:** _____

ALL PATIENTS (OR PARENT/GUARDIAN), PLEASE READ AND SIGN AUTHORIZATION BELOW

Alexandra Pellicena, MD, PA has my permission to use the above information as needed for medical treatment of the patient and to obtain payment for services rendered. Date Signed_____

Signature: _____ **Printed Name** _____

03/2005 **Appointment Date**_____