Welcome to the Office of Robert M. Stern, M.D., Inc.

PATIENT REGISTRATION INFORMATION:

Name: Date of Birth: Age:

Sex: M / F Social Security #:

Address: City: State: Zip:

Home Phone #: Work Phone #:

Cell Phone #: Employed: N / Y - F/T P/T Self-Employed Student

Marital Status: Single / Married / Divorced / Widowed Employer:

Spouse's Name: Employer Address:

or Parent's Name: Employer City:

Contact Preference: Phone / Email / Both Phone&Email Employer State: Zip:

Print Clearly Email Address: Interested in Patient Portal: Y / N

Race: American Indian / Asian / Other Race / White Preferred Pharmacy:

Black or African American / Native Hawaiian or Pacific Islander Pharmacy Address:

Ethnicity: Non- Hispanic or Hispanic Pharmacy Phone:

Primary Doctor Name: Referring Dr Name:

Address: Address:

PCP Phone: Referring Dr Phone:

GUARANTOR / RESPONSIBLE PARTY INFORMATION:

❑ **Check If Same As Patient**

Name: Date of Birth:

Address: City: State: Zip:

Social Security #: Employer:

Home Phone #: Employer Address:

Work Phone #: Employer City:

Cell Phone #: Employer State: Zip:

MEDICAL AND VISION INSURANCE INFORMATION:

Primary Ins: **Secondary Ins:**

Certificate #: Certificate #:

Group #: Copay: $ Group #:

Subscriber Name: Subscriber Name:

Subscriber DOB: Subscriber DOB:

Subscriber SS#: Subscriber SS#:

Vision Ins: Subscriber Name:

Certificate #: Subscriber DOB:

Group Name: Subscriber SS#:

Lifetime Signature on File, Assignment of Payment from Insurance and Release of Information

I hereby authorize direct payment to the physician for services rendered. I agree to be financially responsible to the physician for all charges on my account in the event my insurance fails to reimburse for services outside of contractual agreements, or otherwise determines my insurance benefits are not payable. **I understand I will be responsible for the additional fees added to my account, if my account is sent to a collection agency.** I authorize the release of any medical information required in the processing of financial coverage of all services rendered upon myself or dependents. **I agree to pay any and all insurance co-payments, deductibles and non-covered services at the time service is rendered.**

Patient/Guarantor Signature: _____ Date: _____