Schachner Associates

REGISTRATION FORM/ASSIGNMENT OF BENEFITS

(Please Print)

Today's date:	PCP:	Phone:

PATIENT INFORMATION

Patient's Name (Last, First, Middle Initial):	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	**Relationship status** (circle one) Single/Mar/Div/Sep/Wid/Partnered

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name:	Former Name:	**Birth Date**: / /	**Age**:	**Sex**: ❑ M ❑ F

Street address:	Social Security #:	**Most appropriate phone no**.: ( )

P.O. box:	**City**:	**State**:	**ZIP Code**:

Occupation:	**Employer/School**:	**Employer phone no**.: ( )

Referred to practice by: ❑ Dr. ❑ Family ❑ Friend ❑ Insurance ❑ Hospital ❑ Attorney ❑ Phone Directory ❑ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	**Birth date**: / /	**Address** (if different):	**Home phone no**.: ( )
Is this person also a patient here? ❑ Yes ❑No		**Occupation**:	**Employer phone no**.:
Employer:		**Employer address**:	( )

Is this patient covered (insurance)? ❑ Yes ❑ No

Primary Insurance:	❑ Highmark BCBS	❑ BlueCross/BlueShield	❑ UPMC	❑ Value Options	❑ Medicare
	❑ UBH	❑ Other			

Subscriber's Name:	**Subscriber's S.S. #**:	**Birth date**: / /	**Policy no**.:	**Group no**.:	**Co-Pay**: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	or Partner	❑ Child	❑ Other

Secondary Insurance:	❑ Highmark BCBS	❑ BlueCross/BlueShield	❑ UPMC	❑ Value Options	❑ Medicare
	❑ UBH	❑ Other			

Subscriber's Name:	Subscriber's S.S. #:	Birth date: / /	Policy no.:	Group no.:	Co-Pay: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse or Partner ❑ Child ❑ Other

EMERGENCY CONTACT

Name of local friend or relative:	**Relationship to patient**:	**Home phone no**.: ( )	**Work phone no**.: ( )

Assignment of Benefits: The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Schachner Associates or insurance company to release any information required to process my claims.

Patient/Guardian signature ***Date:***