DR. D. KEVIN LURIE, FACS

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NEW PATIENT REGISTRATION FORM

Today's Date:_____/_____/_____

First Name:_____ MI:_____ Last Name:_____

Address:_____ APT#:_____

City:_____ State:_____ Zip Code:_____

DOB: _____ Gender: F_____ M_____

Social Security Number:_____-_____-_____

Home | Cellular | Work Phone#: _____-_____-_____

Home | Cellular | Work Phone#: _____-_____-_____

Referring/Primary Doctor, Phone#:_____ _____-_____-_____

Emergency Contact:_____ Relationship to Patient:_____

Phone#:_____-_____-_____

Do you currently have **active** insurance coverage? Yes:_____ No:_____

****PLEASE PROVIDE A VALID FORM OF I.D. AND INSURANCE CARD AT TIME OF CHECK-IN****

INSURANCE AUTHORIZATION AND ASSIGNMENT

___I certify that the above information I have reported with regard to my insurance coverage is correct and further authorize the release of my necessary information, including medical information to DR. D. KEVIN LURIE, FACS and/or to my insurance carrier to determine benefits payable for services rendered by the provider of services.

___I authorize the above provider of services to apply for benefits on my behalf from my insurance carrier listed above and request payment for covered services rendered by the above provider of services be made directly to DR. D. KEVIN LURIE, FACS.

___I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either myself or my insurance company at any time in writing and/or electronically.

Signature:_____ Date:_____/_____/_____