Lynda Mandell, M.D., PLLC

PATIENT REGISTRATION FORM

I. Name: ____

(Title) First MI Last

Social Security #: ____________ Date of Birth: __/__/___ Age:____ Sex:____

Home Address: ____

Street Apt #

________________ ________________ ________________

City State Zip Code

Home Tel# ___________ Cell #__________ E-mail address:__________________

Patient's Occupation: ____

Patient's Employer: ____

Business/ Employer Address/Tel/Fax:______________________________________

____

Emergency Contact Person/s: (Name, relationship, age, and contact #s):

____

Referred by: Name: __________________ Relationship:____________________

II. Insurance/Billing Information*:

Name of Primary Insurance Carrier:____

Subscriber ID Number: __________________________ Group Number:______________

Type of Plan (HMO, PPO etc.):______________________

Policy Holder (Subscriber), if not patient (e.g., parent, spouse, partner): Name:__________________

Date of Birth: _______ Social Security #:_____________

Dr. Mandell is not in network with any insurance company, but will assist in insurance claims submission.

III. Credit Card Information:

Name on Card:______________________________

American Express ___ MasterCard ____ Visa____

Card Number :___________________________ Expiration Date:_________

CVV Number(3 or 4 digits): ______

Party responsible for billing/payments, if not patient or subscriber:

Name:_______________________Date of Birth_________ Social Security #:____________

IV. Pharmacy Information:

Retail Pharmacy (Must accept e-prescribe Controlled Substances CS):

Name:________________ Address:________________________ Tel#_____________

Mail Order Pharmacy, if applicable:

Name:_____________ Address:__________________________ Tel#______________

Attestation and Authorization for Billing and Release of Information:

I attest that all provided above is to best of my knowledge.

I, furthermore, authorize Dr. Mandell to 1) bill to the above credit card for fees associated with professional services , inclusive of any late cancellations and outstanding unpaid fees; and 2) release information to my insurance carrier for purposes of insurance information or obligation and claims resolutions and I authorize any holder of medical or other information about the above named patient needed for any insurance claim to be released to Dr. Mandell.

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Patient(Parent (patient <18yrs)/Guardian, if applicable) signature: Date