ERIC M. GROSS, M.D., P.A.

REGISTRATION FORM

(Please Print and complete ALL sections below!)

Primary Doctor:

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐
Race:	Date of Birth:		Sex: ☐ M ☐ F	Referring Physician:	
Social Security #:	Home phone #: ( )		Cell phone #: ( )		
Street address:	City:		State:	ZIP Code:	
Occupation:	Employer:		Work phone #: ( )		

If Minor
Parent Name:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Name of primary insurance:

Policy Holder's name:	Policy Holder's S.S. #:	Birth date:	Policy #:	Group #:

Patient's relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of secondary insurance (if applicable):	Policy Holder's name:	Policy #:	Group #:

Patient's relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone #: ( )	Alternate phone #: ( )

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 Eric M. Gross, M.D., P.A. or insurance company to release any information required to process my claims.

Co-payments are to be collected at the time services are rendered. No payment plans available.

I have read, understand and agree to abide by all the above, release of medical information and payment policies.

Your signature below acknowledges that you have read the notice of privacy practices.

Patient/Guardian signature ***Date***