MURRAY ORBUCH, MD
Patient Registration Form:

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PERSONAL INFORMATION

Last Name:_____First Name:_____M.I.____

Date of Birth:_____SS#:_____

Address:_____Apt #:_____

City:_____State:_____ Zip:_____

Home Phone:_____Business Phone:_____

Employer's Name:_____

Employer's Address:_____

Occupation:_____

Referring M.D.:_____Phone:_____

SPOUSE/PARTNER INFORMATION
Spouse/Partner's Name: _____
Contact # in case of emergency_____

INSURANCE INFORMATION
Primary Carrier: Insurance company to bill first
Insured Name (if other than self)_____ Insured D.O.B._____
Insurance Carrier_____

Secondary Carrier: Insurance company to bill second
Insured Name (if other than self)_____ Insured D.O.B._____
Insurance Carrier_____

I understand that all medical costs incurred by me are my responsibility, including any charges my insurance fails to pay. I also understand that I am responsible for the cost that any collection and/or legal efforts necessary on my account. In the event that my account becomes delinquent and my past due account is forwarded out to collection (be it a collection agency or law firm), I agree to be responsible for the collection fee above and beyond the amount we (provider of services) are owed. These charges are not to exceed 33% of the actual amount owed or outstanding.

PATIENT SIGNATURE _____ DATE_____

MURRAY ORBUCH, MD

Patient Registration Form:

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I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION AND HEALTHCARE FINANCING ADMINISTRATION OR THEIR INTERMEDIARIES OR CARRIERS OR TO THE BILLING AGENT OF THIS PHYSICIAN, ANY INFORMATION NEEDED FOR THIS OR ANY RELATED MEDICAL CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL AND REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS TO MYSELF OR TO A PARTY WHO ACCEPTS ASSIGNMENT. I AUTHORIZE THIS OFFICE TO FURNISH MY INSURANCE CARRIERS WITH ANY INFORMATION RELEVANT TO MY CLAIMS TO MAKE DIRECT PAYMENT IF ACCEPTED. I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT.

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE UNDERSIGNED PHYSICIAN OR SUPPLIER, FOR SERVICES RENDERED.

PRINT NAME _____

PATIENT SIGNATURE _____ DATE_____