REGISTRATION

PERSAUD MEDICAL, PLLC.
Aretha Persaud-Mancusi, MD
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Melville, NY 11747
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Date: ______________ *Home Phone* (____) ______________ *Cell Phone* (____) ______________

PATIENT INFORMATION

Name ______________ *SS ID #* ______________
Last Name *First Name* *Middle Initial*

Address ______________ *E-mail* ______________

City ______________ *State* ______________ *Zip Code* ______________

Sex ▢ *M* ▢ *F* *Age* ________ *Birth Date* ______________ ▢ *Married* ▢ *Widowed* ▢ *Single* ▢ Minor ▢ Separated ▢ Divorced

Patient Employer/School ______________ Occupation ______________

Pharmacy Name ______________ Store Phone (____) ______________ Referred by ______________

In case of emergency who should be notified? ______________ Phone (____) ______________

PRIMARY INSURANCE

Person Responsible for Account ______________
Last Name First Name Middle Initial

Relation to Patient ______________ Birth Date ______________ Soc. Sec. # ______________

Address (if different from patient's) ______________ Phone (____) ______________

City ______________ State ______________ Zip Code ______________

Person Responsible Employed by ______________ Occupation ______________

Business Address ______________ Business Phone (____) ______________

Insurance Company ______________

Member ID # ______________ Group # ______________

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ▢ Yes ▢ No

Subscriber Name ______________ Birth Date ______________ Relation to Patient ______________

Address (if different from patients) ______________ Phone (____) ______________

City ______________ State ______________ Zip Code ______________

Subscriber Employed by ______________ Business Phone (____) ______________

Insurance Company ______________ Soc. Sec. # ______________

Member ID # ______________ Group ______________

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with ______________ and assign directly to **Dr. Persaud** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.
The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services

Signature of Patient, Parent, or Guardian ______________ Date ______________