ZEV ASH M.D., F.A.A.P.
PEDIATRIC AND ADOLESCENT MEDICINE

PATIENT REGISTRATION:

DATE: _____.

NAME _____ **DATE OF BIRTH** _____

ADDRESS _____ **PHONE( )** _____.

FATHERS NAME _____ **OCCUPATION** _____ **BIRTHDATE** _____ **PHONE** _____ **S.S.#** _____

MOTHERS NAME _____ **OCCUPATION** _____ **BIRTHDATE** _____ **PHONE** _____ **S.S.#** _____

EMERGENCY CONTACT; _____ ***PHONE*** _____ ***ADDR.*** _____

INSURANCE INFORMATION:

PERSON RESPONSIBLE; _____.

INSURANCE COMPANY _____ **ADDRESS** _____ **EFFECTIVE DATE** _____

I.D. NUMBER _____ **GROUP** _____ **ADDRESS** _____

OTHER COVERAGE _____ **copay amount** _____

ASSIGNMENT OF INSURANCE BENEFITS:

I HEREBY AUTHORIZE DIRECT PAYMENT OF MEDICAL / BENEFITS TO DR. ZEV ASH FOR SERVICES RENDERED BY HIM IN PERSON OR UNDER HIS SUPERVISION. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY BALANCE NOT COVERED BY MY INSURANCE.

AUTHORIZATION TO RELEASE INFORMATION:

I HEREBY AUTHORIZE DR. ZEV ASH TO RELEASE ANY MEDICAL INFORMATION THAT MAY BE NECESSARY FOR EITHER MEDICAL CARE OR IN PROCEESING APPLICATIONS FOR PAYMENT PURPOSES.

PATIENT _____ **DATE** _____.

Credit Card Company _____

Number _____ **Exp** _____

SIGNATURE _____.