REGISTRATION FORM

(Please Print)

CONTACT INFORMATION					
Last Name:	**First:**	**Middle:**	**Birth Date:**	**Age:**	**Sex:**
Street Address:			**Email Address:**		
City:	**State:**		**ZIP Code:**		
Home Phone No.:	**Work Phone No.:**		**SSN# for imaging registration**		
How did you hear about us?	**How would you like to be contacted?**				
Primary Care Physician:			**Would you like the results sent to your PCP?**		
Occupation:			**Employer:**		
Employer Address:					

DEMOGRAPHICS – FOR REGISTRATION OF TESTING				
Religion:	**Race:**	**Primary Language:**		**Ethnicity:**
Marital Status:	☐**Married**	☐**Single**	☐**Divorced**	☐**Separated**

IN CASE OF EMERGENCY			
Name :	**Relationship to patient:**	**Home phone no.:** **( )**	**Work phone no.:** **( )**

INSURANCE FORM

IF BILLING INSURANCE PLEASE COMPELETE THIS SECTION			
Name of Insured	**Birth date:** **/ /**	**Address (if different):**	**Home phone no.:** **( )**
Name of primary insurance:			
SSN#:	**Group no.:**		**Policy no.:**
Patient's relationship to subscriber:	❑ **Self**	❑ **Spouse**	❑ **Other**
Name of secondary insurance (if applicable):	**Insured's name:**	**Group no.:**	**Policy no.:**
Patient's relationship to subscriber:	❑ **Self**	❑ **Spouse**	❑ **Other**

The above information is true to the best of my knowledge. I, the undersigned, have insurance coverage and assign directly to Dr. Mark Kauffman, and LECOM all insurance medical benefits, if any, otherwise payable to me for services rendered. I understand that services I have selected may not be Covered Services under my insurance plan. I agree to be financially responsible for any/all charges due for uncovered and/or covered services which are not approved. I hereby authorize the doctor to release or obtain all information to secure payment of benefits. I authorize this signature for all insurance release submissions.

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Patient Signature ***Date***