HEAR CLEARLY
Dr. Susan Antonellis
Roslyn, NY 11576
REGISTRATION FORM

Last Name First Name		Middle Initial:	Sex: Male Female
Address:	State:		Zip Code:
Home Phone:	Cell Phone:		Work or Alternate Phone:
Patient's Social Security #:	Date of Birth:	Email Address:	
Single/Married:	Spouse's Name:		
Emergency Contact Name:			
Relationship:	Home Phone:	Work Phone:	
Primary/ENT Physician Name:		Office Phone:	
Physician's Address:			
If not referred to us by your physician, how did you hear about us?			

Guarantor Name:	Date of Birth:	Social Security #
☐ Primary Medical Insurance	☐ Secondary Medical Insurance	
Primary Insurance:	Primary Insurance:	
Subscriber Name (if not patient): _____ Subscriber's Date of Birth: _____	Subscriber Name (if not patient): _____ Subscriber's Date of Birth: _____	
Relationship to Subscriber: ☐Self ☐Spouse ☐Dependent Child ☐ Student ☐ Other	Relationship to Subscriber: ☐Self ☐Spouse ☐Dependent Child ☐ Student ☐ Other	
Certificate ID#: Group#:	Certificate ID#: Group#:	
Address:	Address:	
Phone #: Plan#:	Phone #: Plan #:	
Subscriber Address (if not patient): _____ Subscriber's Date of Birth: _____	Subscriber Address (if not patient): _____ Subscriber's Date of Birth: _____	

Any Additional Insurance: ☐ Medical Insurance

Name of Insurance:	Subscriber Name (If not patient): _____ Subscriber's Date of Birth: _____
Certificate ID#: _____ Plan #:	Group #:
Insurance Address:	

Assignment of Benefits & Authorization to Release Medical Information

I certify that all information above is true and correct. I authorize and direct Dr. Susan Antonellis, having treated me, to release to governmental agencies, insurance carriers or others who are financially liable for my medical care, all information needed to substantiate payment for such medical care and representatives thereof to examine and make copies of all records relating to such care and treatment. I hereby assign, transfer and send over to Dr. Antonellis sufficient monies and/or benefits to which I am entitled from governmental agencies, Insurance carriers or others who are financially liable for my medical care to cover the cost of the care and treatment rendered to myself or my dependents. I request that payment of authorized benefits be made on my behalf, and understand I am responsible for charges not covered by my policy or plan.

Medicare/Medicaid: I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical information about me to release to the SS Administration and HCFA or its intermediaries or carriers any information needed for this or a related Medicare/Medicaid claim request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician furnishing the services or authorize such physician to submit a claim to Medicare/Medicaid insurance payment to me.

Individual Responsibility for Non-Covered Services

In consideration of services rendered by Dr. Susan Antonellis to the undersigned patient, the undersigned promises to pay Dr. Susan Antonellis any co-payment, co-insurance or other charges required to be paid by my medical coverage. In addition, I promise to pay for all services that are not covered by my insurance plan provided I am informed of same prior to the render of said services.

_____ _____
Signature of Patient or Authorized Guardian Date

Authorization to Release Information Via E-Mail

By providing your e-mail address you agree to receive by e-mail address information about your healthcare, including proteced health information.

_____ _____
Signature of Parent or Authorized Guardian Date