

BARRY T. MALIN, M.D.
Adult and Pediatric Urology

PATIENT REGISTRATION

Patient Name: _____ Date: _____

Patient Address: _____ City: _____ ZIP Code: _____

Date of birth: _____ Sex: _____ Phone: _____

Social Security Number: _____ Marital Status: _____

Referring Physician: _____ Primary Care Physician: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Employer: _____ Occupation: _____ Phone: _____

Employer Address: _____ City: _____ ZIP Code: _____

Note: If you are on Medicare and if you or your spouse do not work, Medicare is your **PRIMARY INSURANCE**. If you are disabled, or if you or your spouse work, Medicare is your **SECONDARY INSURANCE**.

Primary Insurance Name: _____ ID Number: _____

Group Number: _____ Prefix: _____

Patient Relationship to Insured: _____

Insured Name: _____

Insured Address: _____ City: _____ ZIP Code: _____

Town or County: _____

Secondary Insurance Name: _____ ID Number: _____

Group Number: _____ Prefix: _____

Patient Relationship to Insured: _____

Insured Name: _____

Insured Address: _____ City: _____ ZIP Code: _____

Town or County: _____

ASSIGNMENT OF INSURANCE BENEFITS & AUTHORIZATION TO RELEASE INFO.

I hereby authorize direct payment to Barry Malin, M.D., for services rendered to me. I understand that I am financially responsible for any balance not covered by my insurance. I also authorize Dr. Malin to release any medical information required to process my claims. If covered by Medicare, I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct and that payment be made to the providing physician for as long as I remain under his care. A photocopy of these assignments shall be valid as the original.

Patient signature: _____ Date: _____