EAST COAST SPINE & ORTHOPEDICS, P.C.
330 NORTH HARRISON STREET, SUITE 4
PRINCETON, NJ 08540
Tel: (609) 955 – 1251
Fax: (888) 255 – 0370

Dr. Steven Schiebert, MD, DO

PATIENT REGISTRATION

Patient Information:

Last Name: ____________________ First Name: ____________________ M.________

Address: ________________________________ Apt or Space #: __________

City: ________________ State: ______ Zip: ______ Marital Status: __________

Social Security Number: _____-_____-_____ Birth Date: __________ Age: ____ Gender: Male/Female

Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________

Employer Name: ______________ Address: ______________________

Primary Doctor: ______________ Referred By: ______________________

Email: ____________________ Pharmacy Name: ______________________

Emergency Contact Information:

Last Name: ____________________ First Name: ____________________ M.________

Address: ________________________________ Apt or Space #: __________

City: ________________ State: ______ Zip: ______ Relationship: __________

Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________

Insurance Information:

Primary Insurance: ______________________

Insured ID #: ______________________

Group #: ______________________

Address: ______________________

City/ State/ Zip: ______________________

Telephone #: ______________________

Policy Owner Name: ______________________

DOB: __________ Relation: __________

Policy Owner Social Security #: ______________

Employer Name: ______________________

Secondary Insurance: ______________________

Insured ID #:______________________

Group #: ______________________

Address: ______________________

City/ State/ Zip: ______________________

Telephone #:______________________

Policy Owner Name: ______________________

DOB: __________ Relation: __________

Policy Owner Social Security #: ______________

Employer Name: ______________________

Reason for Today's Visit: ____

Please Fill Out Form Completely

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AUTHORIZATION AND RELEASE

Authorization for treatment: I voluntarily consent to the administration and cost of medical and surgical procedures for myself or my dependent.

Assignment of Insurance benefits: I authorize payment directly to *East Coast Spine & Orthopedics, P.C.* for all benefits otherwise payable to me.

Guarantee of Payment: I understand that I am financially responsible and agree to pay all charges that are not paid or billed to insurance or any other third party payer. I understand that I must pay in full today for all services rendered unless my insurance is accepted. I also understand that if insurance is accepted that I must pay all applicable insurance co-pays, coinsurance, and deductibles today. If you are unable to verify my insurance at the time of service, I will pay in full for the service.

Release of Records: I authorize *East Coast Spine & Orthopedics, P.C.* to release (verbal or in writing) confidential medical information to any person or entity including my insurance carrier, employer if treatment is related to employment purposes, or other health care operations which may be liable to me or my practitioner(s) for charges for treatment and for quality management, utilization review, transfer, and follow-up purpose.

Receipt of Privacy Practices: I acknowledge that I have received and read the Notice to Privacy Practices of *East Coast Spine & Orthopedics, P.C.*, I understand that a copy of this agreement may be used with the same effectiveness as the original.

Consent of Notification of Test Results:

I give permission to *East Coast Spine & Orthopedics, P.C.* to leave any health information on my answering machine. _______ (Initial)

I give permission to *East Coast Spine & Orthopedics, P.C.* to notify:

____

Relationship: ____________________________________

Patient Signature: ____

Date: ______________________________

Parent or Guardian Signature: ____

Date: ______________________________

Please Fill Out Form Completely