Lawrence A. Berger M.D., P.A.
Cardiology Internal Medicine

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Today's date:	**Primary Care Physician:**

PATIENT REGISTRATION

First name:	**M.I:**	**Last:**	**Race :** ❑ White ❑ Black or African American ❑ American Indian ❑ Asian ❑ Hispanic ❑ Native Hawaiian ❑ Other

Ethnicity: ❑ Hispanic / Latino ❑ Not Hispanic / Latino	**Marital status (circle one)** Single / Mar / Div / Sep / Wid	**Preferred Language**	**Sex:** ❑ M ❑ F	**Age:**	**Birth date:** / /

Social Security no.:	**Home phone no.:** ( )	**Cell phone no.:** ( )	**E-mail Address:**

Street address:	**Apt:**	**City:**	**State:**	**ZIP Code:**

Occupation:	**Employer:**	**Employer phone no.:** ( )

Referred to our office by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Internet	❑ Other

Other family members seen here:

Preferred Pharmacy Name & Phone No. :

INSURANCE INFORMATION

*****There will be a $25.00 charge for returned checks**.***

To Help Prevent Identity Theft, Federal Law Requires Us to ask for a Photo ID
(Please give your insurance card & photo ID to the receptionist)

Person responsible for bill:	**Birth date:** / /	**Address (if different):**	**Home phone no.:** ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	**Employer:**	**Employer address:**	**Employer phone no.:** ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Primary Insurance

Subscriber's name:	**Subscriber's S.S. no.:**	**Birth date:**	**Group no.:**	**Policy no.:**	**Co-payment:** $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	**Subscriber's name:**	**Group no.:**	**Policy no.:**

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative:	**Relationship:**	**Home phone no.:** ( )	**Cell phone no.:** ( )	**Work phone no.:** ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Dr. Berger's Office or insurance company to release any information required to process my claims.

Patient/Guardian signature ***Date***