PRIMARY MEDICAL SERVICES, P.C.
FAMILY MEDICINE & URGENT CARE
PATRYCJA CZESNOWSKI, M.D.

PATIENT'S REGISTRATION INFORMATION

Patient's Personal Information: * Please PRINT and complete all sections below

Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed Sex: [ ] Male [ ] Female

Name: _____ DOB: ____ / ____ / ____
LAST FIRST MIDDLE

Social Security #: ____ - ____ - ____ E-mail Address: _____

Home #: (____)____ Cell #: (____)____ Work #: (____)____

Address: _____ APT #: ____ City: _____

State: ____ Zip Code: ____

Patient's Responsible Party Information: * If Self, circle and move to next section

Relationship to Patient: [ ] Self [ ] Spouse [ ] Parent [ ] Other Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed

Name: _____ DOB: ____ / ____ / ____
LAST FIRST MIDDLE

Social Security #: ____ - ____ - ____ E-mail Address: _____

Home #: (____)____ Cell #: (____)____ Work #: (____)____

Address: _____ APT #: ____ City: _____

State: ____ Zip Code: ____

Patient's Insurance Information:

Primary Insurance Name: _____

Primary Insurance Address: _____ City: _____

State: ____ Zip Code: ____ Group #: _____ Policy #: _____

Copay $: ____ Name of Insured: _____ DOB: ____ / ____ / ____

Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed Patient's Relationship to Insured: [ ] Self [ ] Spouse [ ] Child [ ]

Other: ____ Insured Person's Employer: _____

Secondary Insurance Name: _____

Secondary Insurance Address: _____ City: _____

State: ____ Zip Code: ____ Group #: _____ Policy #: _____

Copay $: ____ Name of Insured: _____ DOB: ____ / ____ / ____

Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed Patient's Relationship to Insured: [ ] Self [ ] Spouse [ ] Child [ ]

Other: ____ Insured Person's Employer: _____

Previous Primary Care Doctor:

Name: _____

Address: _____ City: _____

State: ____ Zip Code: ____ Phone #: (____)____ Fax #: (____)____

Emergency Contact:

Name: _____ Relationship: _____

Home #: (____)____ Cell #: (____)____ Work #: (____)____

Address: _____ APT #: ____ City: _____

State: ____ Zip Code: ____

Assignment of Benefits * Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Dr. Czesnowski, M.D. and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default I agree to pay all costs of collections, reasonable attorney's fees. I hereby authorize this healthcare provided to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Date: ____ / ____ / ____ Your Signature: _____

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