

KEITH A. KOBET, M.D., P.C.

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Name: _____

Address: _____

City, State, Zip: _____

Preferred Phone: _____ Home
 Cell
 Work

Alternate Phone: _____ Home
 Cell
 Work

Emergency Contact Name: _____

Emergency Contact Phone: _____

Social Security Number: _____

E-Mail Address: _____

Date of Birth: _____ Age: _____

TODAY'S DATE: _____

Marital Status:

Married Single

Divorced Widowed

Ethnicity:

Not Hispanic or Latino

Hispanic or Latino

Unknown

Race:

White Black or African American

Asian American Indian or
Alaskan Native

Native Hawaiian or Other Pacific Islander

Other

PATIENT'S EMPLOYMENT INFORMATION

Employer's Name: _____

Employed Retired

Employer's Phone: _____

Student/Child Unemployed

Occupation: _____

PRIMARY INSURANCE INFORMATION

Insurance Company Name: _____

ID No.: _____

Subscriber Name: _____

Subscriber's SS No.: _____

Relationship to Patient: _____

Subscriber's Date of Birth: _____

SECONDARY INSURANCE INFORMATION

Insurance Company Name: _____

ID No.: _____

Subscriber Name: _____

Subscriber's SS No.: _____

Relationship to Patient: _____

Subscriber's Date of Birth: _____

• PLEASE BRING INSURANCE CARDS AND DRIVER'S LICENSE TO FRONT DESK •

PATIENT'S PHYSICIAN INFORMATION

Referring Physician: _____

Primary Care Physician: _____

Address: _____

Address: _____

Phone: _____

Phone: _____

Financial Policy Statement

Welcome to Keith A. Kobet, M.D., P.C., we are pleased you have chosen our practice for your medical care. We are committed to providing you with the highest quality services available. Please read and sign the following policy. If we are contracted with your insurance company, we will accept assignment. **All co-pays, co-insurance and deductibles are due and payable at time of service. Failure to provide necessary referrals or current accurate billing information will result in all charges for services being the sole responsibility of the patient/responsible party.** You are expected to understand your benefits coverage and financial responsibility. If we do not have a contractual obligation with your insurance company, you are responsible for 100% of the payment at time of service. You will be responsible for any balances not covered by your insurance. A return check fee of \$25 will be assessed if your check is returned by your bank.

Patient/Guardian Signature: _____ Date: _____

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Address: _____

City, State, Zip: _____

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 Home
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Alternate Phone: _____
 Home
 Cell
 Work

Alternate Phone: OLD _____
 Home
 Cell
 Work

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Primary Care Physician: _____

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Phone: _____

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