Celina Nadelman, M.D. Laboratory Director
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REGISTRATION
(PLEASE PRINT)

Date ________________ **Home Phone**__________________
Patient ____
Last Name First Name Initial
Responsible party (if a minor)______________________________
Street Address____
City____________________________ **State**_____________ **Zip** ________________
Gender Male Female Single Married Widowed Separated Divorced
Age ___________________ **Birthdate** __________________________
Patient Social Security No. ____________________________________
Patient Employed by____
Business address ____
Occupation _________________________________ **Business phone** ______________
Other phone (i.e. cell phone) where you may be reached _______________________
Spouse (or responsible party) Name _______________________ **Birthdate** ________
Patient Employed by____
Business Name and Address______________________________________
Occupation _________________________________ **Business phone** ______________
Who is responsible for this account?_______**Relationship to Patient**_____________
Nearest relative not living with you _______________________ **Phone** ___________
In case of Emergency, who should be notified?_______________ **Phone** ___________
Referred By ____________________________ **Phone** _________________________
Primary Physician _______________________ **Phone** _________________________
Primary Insurance Company ____
Insured Name __________________________________ **Date of Birth** _____________
Social Security No.____
Group or Policy No.____________________ **Subscriber No.** _____________________
Secondary Insurance Company ____
Insured Name __________________________________ **Date of Birth** _____________
Social Security No.____
Group or Policy No.____________________ **Subscriber No.** _____________________

ASSIGNMENT OF BENEFITS AND RELEASE
I, the undersigned, have insurance coverage with ______________________________
Name of Insurance Company
and I assign payment of authorized Medicare benefits and any other medical and/or surgical benefits to which I am entitled, directly to Precision Aspiration and Biopsy, for any services furnished me by the physician, Dr. Nadelman. I understand that I am financially responsible for all charges, whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

____ **Date** ____________________
Name of Insured/Guardian