Celina M. Nadelman, M.D.
Fine Needle Aspiration Specialist
Laboratory Director Precision Aspiration & Biopsy
Tel: (310) 702-6701 Fax: (310) 935-3039

REGISTRATION FORM
(please print neatly)

PATIENT INFORMATION

Name:_____
Last First Middle Initial

Date of Birth:_____/_____/_____ **Gender**: M/F/Other (circle one)

Primary phone number:(_____)_____ (mobile/home) (circle one)

Email Address:_____ **Occupation**: _____

Home Address: _____

City:_____ **State**:_____ **Zip Code**:_____

Are you the primary insurance policy holder? Yes/ No (circle one)

Primary policy holder: _____

Primary policy holder's **date of birth**: :_____/_____/_____ Primary Policy holder's **gender**: M/F

Relationship to policy holder: _____

Primary policy holder's **phone number**: (_____)_____

Primary policy holder's **home address**: _____

Primary Insurance Co:_____ **Primary Policy ID**:_____

Primary Policy **Group** No: _____

Secondary Insurance Co:_____ Insurance number:_____

I, the undersigned, have insurance coverage with_____
and I assign payment of authorized healthcare benefits and any other medical and/or surgical benefits to which I am entitled directly to **Celina M. Nadelman, MD** and **Precision Aspiration & Biopsy** Laboratory, for any services furnished to me by the physician (Dr. Celina 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 payment of benefits or payment thereof. I authorize the use of this signature on all my insurance submissions.

_____ Date: _____
Name of the insured/guardian