Sima Stein, M.D.
Patient Registration Sheet
Please Print

Patient Name ______________________________ **M / F** **Birthdate** ______________

Sibling Name ______________________________ **M / F** **Birthdate** ______________

Sibling Name ______________________________ **M / F** **Birthdate** ______________

Sibling Name ______________________________ **M / F** **Birthdate** ______________

Sibling Name ______________________________ **M / F** **Birthdate** ______________

Address ______________________ **City** ______________________

State ________ **Zip** ____________ **Home Phone** ______________________

E-Mail ______________________________

Pediatrician ☐ **Dr Stein**

Emergency Contact ______________________________ **Phone** ______________

Mother's Name (Last, First, MI) ______________________ **SS#** ______________

Birthdate ____________ **Cell Phone** ______________ **Work Phone** ______________

Fathers Name (Last, First, MI) ______________________ **SS#** ______________

Birthdate ____________ **Cell Phone** ______________ **Work Phone** ______________

Primary Insurance Coverage ______________________________

ID# ______________________________ **Group #** ______________

Subscriber Name ______________________ **Medical Group** ______________

Secondary Insurance Coverage ______________________________

ID# ______________________________ **Group #** ______________

Subscriber Name ______________________ **Medical Group** ______________

We were referred by: (Please circle all that apply) **PHONE BOOK** **INTERNET** **FRIEND** **HOSPITAL** **PHYSICIAN**

Name of Referral (if known) ______________________________

Consent for Use and / or Disclosure of Information: I hereby give consent to Sima Stein, M.D., to use and disclose my protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose your protected health information. You have the right to review our Notice of Privacy Practices before you sign this consent. We reserve the right to change the terms of our Notice Privacy Practices. You may obtain a copy of the current notice by requesting it at the time of your appointment or submitting a written request to the address below. You have the right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required to grant your request, but if we do, the restriction will be binding on us. You may revoke this consent at any time. Your revocation must be in writing, signed by you or on your behalf, and delivered to the address at the foot of this form. You may deliver your revocation by any means you choose, but it will effective only when we actually receive it. Your revocation will not be effective to the extent that we, or others have acted in reliance upon this consent.

Sign ______________________________ **Date** ______________

Print Name of Patient ______________________________

If you are signing as the patient's representative:

Print your Name ______________________ **Relationship to Patient** ______________

ELIGIBILITY AND BENEFITS WAIVER

Dear Parent:

The services and immunizations and/or vaccines, that you receive from Sima Stein, M.D. may be covered by your insurance plan. We will assist you in submitting your claims for services to your insurance carrier. However, due to the myriad of coverage options, you are strongly encouraged to contact your carrier to determine your specific benefits. Please note that you will receive services with the understanding that, in the event your coverage is not effective or your policy does not provide benefits for services rendered, you will be held financially responsible.

______________________________ ______________________________

Patient Name (Please Print) Subscriber's Name

______________________________ __________________ __________

Insurance Plan Name ID # Group #

I, ________________________, understand that if this or any other visit precedes and/or exceeds the effective dates of my insurance coverage, I will be held financially responsible for all related fees incurred. I also understand that if I fail to obtain pre-authorization as required by my insurance plan, prior to receiving services, I will be responsible for paying any related charges. The prepayment made at time of service will be applied toward any balance not covered by your insurance. Refunds will be processed after the insurance has completed adjudicating the claim. In the event that services are not a covered benefit of my insurance coverage, I will be responsible for payment.

________________________ ________ ________________ ________

Parent's Signature Date Witness Signature Date