Please complete the following patient registration information:

First Name_____MI_____Last Name_____

Home Address:_____ SSN:_____

City, State, Zip:_____

Date of Birth:_____Age:_____Gender: (circle one) Male Female

Marital Status: (circle one) Married, Divorced, Single, Widow

Please indicate by placing a 1, 2, or 3 next to each phone number below to indicate the order in which you would like us to contact you.

☐ Home Phone#_____

☐ Work Phone#_____It is o.k. to contact me at work

☐ Cell Phone#_____

Home/Personal E-mail_____
Work/Business E-mail_____
May we send confidential communication to you via the e-mail listed above? (circle one) Yes or No

Name of Person to contact in an Emergency:_____

Their Phone#:_____Your relationship:_____

May we send a report of our findings, recommendations findings to your family doctor? ☐Yes ☐No

Name of your family doctor: _____

Name of your GYN doctor:_____

List your primary language, **if other than English** _____

Race: (circle one) White, Black or African American, Native Hawaiian or other Pacific Island, Asian,

American Indian or Alaska Native, Other _____

Ethnicity (circle one) **:** Hispanic / Latino or Not Hispanic / Latino

Patient Initials :_____

Assignment of Benefits:

Gary Dworkin, M.D. is hereby authorized to furnish information to insurance carriers concerning my illness and treatments, and to collect all payments for medical services rendered to my dependents or myself. I understand that I am responsible for any amount not covered or paid by insurance. I am also responsible for any deductible, co-pay and/or co-insurance at the time services are rendered. I certify that the information I have reported with regard to my insurance coverage is correct. I agree to forward any funds to VST that I directly receive from my insurance company as payment for billed services. I permit a copy of this authorization to be used in place of the original. I have the right to revoke this authorization at any time in writing.

Patient Signature: _____ Date: _____

Guardian

Signature: _____ Date: _____

HOW DID YOU HEAR ABOUT US?

My Physician (Name) _____

Website (Name) _____

Health Insurance Referral

A Friend/Family Member (Name) _____

Internet Search (circle one)-Google , Yahoo , YELP , or Other: _____

Newsletter or Mailer (Name)_____

Newspaper Article or Advertisement: (circle one) TBT (Daily free paper) ,Tampa Bay Times

Other (Please provide details)_____

Patient Initials :_____

Insurance Information:

Please provide our receptionist with your Driver's License
and any/all health insurance cards
so we may make a copy of these cards and keep them in your file.

Please complete the following information, then sign and date below:

Name of Primary Insurance Company:_____

Is the above Primary Insurance Policy in your name? Yes☐ No☐

If the above primary insurance policy is **NOT** in your name, please provide the following information:

Name of the Policy Holder:_____

Social Security # of the Policy Holder:_____

Date of Birth of the Policy Holder:_____

Your Relationship to the Policy Holder:_____

Name of Secondary Insurance Company:_____

Is the above Secondary Insurance Policy in your name? Yes☐ No☐

If the above secondary insurance policy is **NOT** in your name, please provide the following information:

Name of the Policy Holder:_____

Social Security # of the Policy Holder:_____

Date of Birth of the Policy Holder:_____

Your Relationship to the Policy Holder:_____

_____ _____

Patient/Guardian Signature Date

Patient Initials :_____

This is to authorize the following non-medical person(s) to speak with your physician regarding your medical condition:

Name:	Relationship:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Print Patient name :_____

_____	_____
Patient/Guardian Signature	Date

Patient Initials :_____