Barbara Anne Hessel MD
6915 Yellowstone Boulevard Suite 3
Forest Hills New York, 11375
718-275-7200

PATIENT REGISTRATION FORM

NAME:____DOB: __________SEX_____

SOCIAL SECURITY #_____________________________MARITAL STATUS: M S W D

ADDRESS&APT#_____________________________CITY_________STATE____ZIP_______

HOME (____) ____________________________CELL/WORK (____) ____________________

EMPLOYER_________________________ADDRESS_________________________________

SPOUSE NAME_____________________________ DOB: __________________SEX________

SPOUSE'S EMPLOYER______________________PHONE (_____) ______________________

EMERGENCY CONTACT _____________________________ PHONE (____) ______________

EMAIL ADDRESS____

REFERRED TO DR.HESSEL BY (PLEASE CHECK ONE)

__Dr.________________ __ Insurance Plan __ Hospital __ Family or Friend___________

__Close to home/work __Yellow Pages __Other____________________

PRIMARY INSURANCE CO___________________________ ID#________________________

GROUP#___________________________ INS. PHONE# (_____) ________________________

POLICY HOLDER NAME_______________ RELATIONSHIP TO PATIENT________________

SECONDARY INSURANCE CO_____________________________ ID#__________________

GROUP#__________________________________INS. PHONE# (____) ____________________

POLICY HOLDER NAME __________________ RELATIONSHIP TO PATIENT_____________

AUTHORIZATION FOR RELEASE OF INFORMATIONI hereby authorize and direct the above named practice, having treated me, to release to governmental agencies, insurance carriers, or others who are financially liable for my medical care, all information needed to substantiate payment for such medical care and to permit representatives thereof to examine and make copies of all records relating to such care and treatment.

ASSIGNMENT OF BENEFITS I hereby assign, transfer, and set over to the above named practice sufficient moneys and/or benefits to which I may be entitled from government agencies, insurance carriers or others who are liable for medical care to cover the costs of the care and treatment rendered to myself and/or my dependent in said practice.

MANAGED CARE WAIVER FOR NON-COVERED SERVICES Your healthcare insurance plan may not pay the cost for all services provided to you by the practice. Examples include well visits, immunizations, etc. Therefore your healthcare insurance plan may deny any claim for some of the services that you are receiving. I do hereby acknowledge that I have been notified that my healthcare insurance plan may deny payment for the services received at the practice. I therefore agree to be personally responsible for the payment of these services.

SIGNATURE____DATE________________

Date___-___-___

To Whom It May Concern:

AUTHORIZATION FOR PATIENT'S MEDICAL RECORDS

I, the undersigned, do hereby authorize any hospital, physician or other person who has attended me or examined me to furnish to Barbara Anne Hessel, M.D., any and all information with respect to any illness or injury, medical history, consultation, prescription, or treatment, and copies of all hospital or medical records. A photo copy of this Authorization shall be considered as effective and valid as the original.

AUTORIZACION DEL PACIENTE PARA EL PEDIDO DE HISTORIA CLINICA

Autorizo por la presente a cualquier hospital o medico que me haya atendido or examinado, a suministrar a Barbara Anne Hessel, M.D., P.L.L.C., informacion sobre me enfermedad o lesion, historia medica, consultas, recetas o tratamientos, asi como copias de historia de hospital o consultorio medico (o fotocopia de todo si fuera requerido). Una fotocopia de esta Autorizacion sera considerada tan efectiva y valida como el original.

	____/_____/____
Patient's Name	Date of Birth
Signature	Authorized Signature if Patient Unable to Sign
Date	Signature of Translator