Midtown Neurology & Aesthetics
Alina Rabinovich, M.D.

PATIENT INFORMATION/DEMOGRAPHICS

Referred By:_____
Specialty:_____

Primary Care Doctor:_____
Tel:_____ Fax:_____

Pharmacy:_____ Tel:_____
Address:_____

PATIENT Last Name: _____First Name: _____
Date of Birth:_____
Mailing Address: _____
Home phone: _____Do we have permission to leave message?_____
Cell phone: _____
Do we have permission to leave a message/Text?_____

Person to contact in case of emergency (Name, Relation & Phone numbers) ***REQUIRED***:
_____

Insurance Information:
Primary Insurance Company Name: _____
ID Number: _____ Group:_____
Name, date of birth, relationship of the person who is the insured (Spouse, Father, Mother, Other):

ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION
I hereby irrevocably assign the insurance benefit payment, both basic and major medical, to which I am entitled directly to the doctor rendering service. I understand that I am financially responsible for the charges not covered by the assignment. For all OUT-OF-NETWORK claims for services rendered and submitted on my behalf to the insurance, I agree to bring to the doctor any checks received by me from the insurance company. If I pay upfront in full for services rendered to me at the time of appointment and the doctor submits to the insurance co on my behalf, I may keep the checks sent to me by the insurance as reimbursement. A Photostat of this authorization is accepted with the same authority as the original. I hereby authorize the doctor rendering service to release any information required in the course of my examination or treatment.

Insured's Signature***REQUIRED*:** _____
Date:_____
Person who is financially responsible if other than the patient***REQUIRED***:_____
Date: _____

MIDTOWN NEUROLOGY & AESTHTICS
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