ABRAHAM MIKALOV, MD
PATIENT REGISTRATION INFORMATION

LAST NAME　FIRST NAME　MI　TODAY'S DATE

STREET ADDRESS　CITY　STATE　ZIP

HOME TELEPHONE #　WORK TELEPHONE #　CELLULAR (MOBILE) NUMBER

DATE OF BIRTH　AGE　SOCIAL SECURITY NUMBER

M　F
GENDER (CIRCLE ONE)

M　S　D　W
MARITAL STATUS (CIRCLE ONE)

PRIMARY INSURANCE INFORMATION
(PLEASE GIVE YOUR INSURANCE CARD(S) TO A MEMBER OF OUR STAFF)

INSURANCE COMPANY NAME　INSURED'S FULL NAME　I NSURED'S BIRTHDATE　SELF　SPOUSE　CHILD　RELATIONSHIP (CIRCLE ONE)

ID NUMBER, GROUP NUMBER AND/OR POLICY NUMBER

CLAIMS FILING ADDRESS　STREET ADDRESS　CITY　STATE　ZIP CODE

EMPLOYER NAME　EMPLOYER ADDRESS　CITY　STATE　ZIP CODE

SECONDARY INSURANCE INFORMATION (Pleas skip if not applicable and go to next section)

INSURANCE COMPANY　INSURED'S FULL NAME　INSURED'S BIRTHDATE　SELF　SPOUSE　CHILD　RELATIONSHIP (CIRCLE ONE)

CLAIMS FILING ADDRESS　STREET ADDRESS　CITY　STATE　ZIP

INSURED'S ID NUMBER, GROUP NUMBER AND/OR POLICY NUMBER

EMPLOYER NAME　EMPLOYER ADDRESS　EMPLOYER TELEPHONE NUMBER

SPOUSE INFORMATION (IF YOU ARE A MINOR, PLEASE GIVE PARENT INFORMATION)
(If not applicable, please go to next section)

FULL NAME　DATE OF BIRTH　SOCIAL SECURITY NUMBER

EMPLOYER NAME,　EMPLOYER ADDRESSS　EMPLOYER'S TELEPHONE NUMBER

OTHER INFORMATION

REFERRED TO OUR OFFICE BY?　OTHER PHYSICIAN (S) ?

EMERGENCY CONTACT　RELATIONSHIIP　TELEPHONE NUMBER

CURRENT MEDICATIONS

PHARMACY NAME AND TELEPHONE NUMBER　LIST KNOWN ALLERGIES

I ____, HEREBY AUTHORIZE, ABRAHAM MIKALOV,MD TO PROVIDE MEDICAL CARE AND SERICES TO ME, MY SPOUSE OR MY DEPENDENT. I HEREBY ASSIGN ABRAHAM MIKALOV, M.D. ANY AND ALL RIGHTS UNDER MY INSURANCE POLICY WITH ________________________________

AND I HEREBY DIRECT MY INSURANCE COMPANY TO PAY ANY AND ALL PROCEEDS PAYABLE UNDER THE TERMS OF THE PROVISION OF MY INSURANCE POLICY/CONTRACT.I ALSO CONSENT TO THE RELEASE OF ALL MEDICAL INFORMATION REQUIRED TO OBTAIN PAYMENT FROM THE ABOVE NAMED INSURANCE COMPANY. IN THE EVENT THAT THE ABOVE NAMED INSURANCE COMPANY DOES NOT PAY THE ENTIRE AMOUNT OF THE BILL OR STATEMENT RENDERED BY THE ABOVE NAMED PHYSICIAN FOR MEDICAL CARE SERVICES PROVIDED TO ME, MY SPOUSE OR MY DEPENDENT, I GUARANTEE AND PROMISE TO MAKE PAYMENT OF ANY AMOUNT, WHICH THE INSURANCE DOES NOT PAY FOR WHICH I AM DEEMED RESPONSIBLE.

SIGNATURE　TODAY'S DATE