PATIENT REGISTRATION

ACCOUNT NUMBER: _______________

PATIENT NAME: _________________________________ HOME PHONE: _____________________

HOME ADDRESS: ________________________________ CELL/WORK PHONE: ________________

CITY: ________________________STATE:_______ZIP: _________MARITAL STATUS: S M W D

EMPLOYER: _______________________EMAIL: ____.

BIRTHDATE: ___________________AGE: ___________ SEX: ___________

SOCIAL SECURITY NUMBER: _____________________

EMERGENCY CONTACT: ________________________ TELEPHONE NUMBER: _____________

Whom may we thank for referring you to us? ____

PRIMARY CARE PHYSICIAN: ____

ACKNOWLEDGEMENT OF RECEIPT OF PATIENT PRIVACY NOTICE

I have received a copy of Dr. Michael C. Glafkides' Patient Privacy Notice.

Signature: _________________________________ Date: ___________________________

CONSENT TO RELEASE MEDICAL INFORMATION

I hereby authorize Michael C. Glafkides, M.D. to disclose protected health information as described in The Patient Privacy Notice for treatment, payment or health care operations purposes. I also authorize Michael C. Glafkides, M.D. to release information to any Hospital or Physician I may be referred to by this office.

Signature: _________________________________ Date: ___________________________

ASSIGNMENT OF BENEFITS

I hereby authorize assignment and payment directly to Michael C. Glafkides, M.D. of any insurance benefits due me.

I HEREBY AGREE TO PAY ANY CHARGES AND ALL CO-PAYMENTS OR DEDUCTIBLES AS SPECIFIED BY MY INSURANCE COVERAGE OR THOSE CHARGES THAT ARE NOT COVERED BY MY INSURANCE.

Signature: ___________________________________ Date: _____________________________

a/o 06/27/2007