

**Teresa Hoffman, M.D. & Associates, LLC**

**PATIENT REGISTRATION - PLEASE PRINT CLEARLY**

Patient Name First Middle Last			Name You Wish to be Called	Date of Birth	Age
Home Address Apt. No.			City, State & Zip Code		
Occupation	Social Security No.		Marital Status Single Married Separated Divorced Widowed Partnered		
Cell Phone	E-Mail Address		Home Phone		
Employer (or previous employer, if retired)	Work Address		Work Phone – ext		
Name of Insured Person and Relationship to You			Social Security No. of Insured Person		
Address of Insured Person		Date of Birth of Insured Person		Phone No. of Insured Person	
Name of Spouse (or Parent)		Home Phone		Cellular Phone	
Address of Spouse (or Parent)		Work Phone			
Emergency Contact		Relationship	Home Phone	Work Phone – ext	
Emergency Contact Address					
Primary Care Physician		Address		Office Phone	

**COPY OF INSURANCE CARD**

**Patient Authorization**

I certify that the information I have reported with regard to my health insurance coverage is correct and I have read and understand the Insurance and Billing information and patient policies. I authorize the release of any necessary information, including medical information for this and any related claim, to the above named Insurance Company (or in the case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration)/Medicare in order to determine benefits to which I may be entitled. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either the above named carrier or me at any time.

**Acknowledgment of Receipt of Privacy Notice**

I acknowledge that I have received information regarding the privacy notice.

Date	Signature of Subscriber or Beneficiary
Date	Signature of Subscriber or Beneficiary
Date	Signature of Subscriber or Beneficiary